Communities of Excellence
in Tobacco Control

A Communities of Excellence Needs Assessment Guide

California Department of Public Health
California Tobacco Control Program

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Communities of Excellence in Tobacco Control: A Framework for Assessing Community Tobacco Control Needs

Introduction

This manual provides information about the California Tobacco Control Program's (CTCP) social norm change strategy and how the Communities of Excellence (CX) needs assessment framework supports this strategy. It describes the historical context for developing CX, its evolution, and updated tools and instructions for exploring your community's tobacco control-related needs.

Social Norm Change

The ultimate goal of tobacco control work is to reduce and eventually eliminate death and disease resulting from tobacco use and exposure to secondhand smoke. However, unlike diphtheria, pertussis, and tetanus, currently there is no vaccine to inoculate the public against the harmful effects caused by tobacco use.

California's approach to protecting the public's health and preventing tobacco-related diseases and illnesses such as cancer, cardiovascular disease, premature births, sudden infant death syndrome, emphysema, and asthma is achieved through a social norm change strategy. While California's denormalization strategy does not preclude the education of individuals, it emphasizes changing norms in the larger physical and social environment, rather than changing the behavior of individuals. It seeks to impact the diverse and complex social, cultural, economic, and political factors which foster and support continued tobacco use.

California's social norm change strategy is a cost-effective and efficient approach because the strategy involves creating population-level changes such as the adoption of policies that lead to reduced smoking rates and decreased exposure to secondhand smoke. The social norm change strategy works on the premise that as new people or businesses move into the community, they inherit and adopt the established norms about smoking and the promotion and sale of tobacco, (e.g., not smoking in restaurants, not being able to sell cigarettes without a license, etc.).

Overall, California's social norm change strategy seeks to create an environment where tobacco use becomes less desirable, less acceptable, and less accessible. Through community interventions, the provision of statewide training and technical assistance, and a mass media campaign, CTCP works to achieve social norm changes which sum to create a

significant decrease in tobacco use at the population level. Community interventions that focus on policy, environmental, and system-level change are the building blocks of social norm change and play a vital role in changing and sustaining social norms.

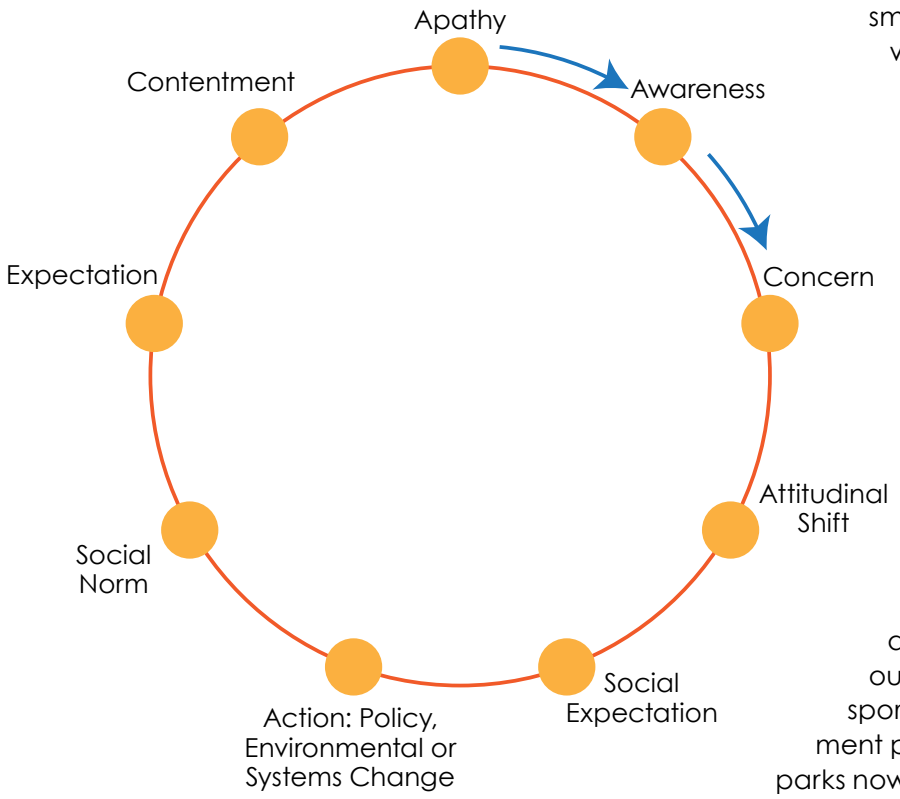
California's social norm change strategy relies on a comprehensive cross-cutting population approach. It seeks to create changes that impact every member of the community and social structure rather than focusing on individual population groups such as youth. The social norm change strategy recognizes that people don't live in silos and that community-wide changes impact all the groups in that community, provided that the policies and system changes adopted don't allow for exemptions which protect or benefit some members of the community more than others. California's social norm change strategy also recognizes that adults are an important audience for education and awareness-raising efforts as adults exert considerable influence and control over a community's tobacco use norms. It is adults who make decisions to:

- Raise taxes on tobacco products and designate a portion of that revenue for tobacco use prevention and cessation;
- Enact laws to protect the public and workers from exposure to secondhand smoke;
- Dedicate funding for smoking cessation services and other tobacco control efforts;
- Prioritize enforcement of tobacco control laws;
- Market, promote and sell tobacco products in a way that is appealing to young people; and
- Glamorize and model smoking through the movies.

The social norm change strategy, illustrated by the Social Issue Cycle (Figure 1), works by moving a community or organization along a cyclical continuum that may begin with **apathy** for an issue. Through education and outreach, **awareness** is raised which results in **concern** for an issue and a **shift in attitudes**. These attitudinal changes create a **social expectation** that **action** will be taken to resolve the issue. In turn, the social expectation for action provides the political will necessary to support policy, environment or system-level changes which result in a new **social norm**. As the new social norm is broadly adopted, there is an **expectation** that people, communities, and organizations will conform to the new social norm resulting in **contentment**.

The Social Issue Cycle is not static. It is constantly evolving. One example of the Social Issue Cycle in action in California concerns secondhand smoke exposure. When CTCP was launched in 1989, smoking was permissible on airplanes, in hospitals, and in most workplaces. Through statewide media and community interventions, communities became aware and concerned about secondhand smoke exposure in enclosed spaces. This concern led to changes in attitudes about the acceptance of exposure to secondhand smoke, which created support for policies restricting smoking on airplanes, at worksites and in bars. As local and statewide clean indoor air policies were adopted, the social norm changed and people began to expect smoke-free environments. While initially controversial, today there is widespread contentment with clean indoor air policies. In California, the expectation for protection from secondhand smoke exposure has moved to a similar expectation in outdoor settings. Numerous sporting stadiums, amusement parks, beaches, and parks now restrict smoking.

Social Issue Cycle
Figure 1



Development of CX

What are the requirements for needs assessments and local planning?

In November 1988, California voters approved the Tobacco Tax and Health Promotion Act of 1988 (Proposition 99) which raised the tobacco tax in California by 25 cents and earmarked that 20 percent of the funds collected be allocated to a comprehensive tobacco control program jointly administered by the California Department of Public Health (CDPH) and the California Department of Education. The enabling legislation that established California's comprehensive tobacco control program designated the 61 health departments that serve 58 counties and 3 cities as Local Lead Agencies (local health departments).

The enabling legislation for Proposition 99 requires local health departments to periodically submit a comprehensive tobacco control plan to CDPH and to obtain the involvement of local community organizations in the development of that plan. The legislation requires that the plan provide demographic information; local data on smoking and tobacco use; a description of program goals and objectives, target populations, activities, evaluation,

and budget cost estimates for program activities; and budget information including staffing configurations and computer hardware and software needs. Additionally, local health departments are required to use a uniform management data and information system, which permits comparisons of workload, unit costs, and outcome measurements on a statewide basis.

Why did CTCP develop the CX needs assessment process?

Development of the CX framework began in the late 1990s and was stimulated by several factors. After a decade of funding local tobacco control programs, CTCP believed it was important for local health departments to take a critical look at their communities to determine what had been accomplished in the past decade and what remained to be done. Additionally, two major events occurred in 1998. These were the 1998 Master Settlement Agreement (MSA) and enactment of the 1998 California Children and Families (CCF) Act (Proposition 10) which raised the cigarette excise tax by 50 cents per pack beginning in January 1999. These events had the potential to dramatically alter California's tobacco control landscape.

The MSA between major United States tobacco companies and 46 Attorneys General was projected to result in $25 billion in payments to California through 2025. A Memorandum of Understanding (MOU) signed between the California Attorney General and local governments designated a 50-50 split of the tobacco industry payments with the state receiving $12.5 billion and local governments dividing $12.5 billion among themselves. Under the terms of the MOU, 90 percent of the funds were distributed to the 58 counties based on population. The remaining funds were equally split between four cities (Los Angeles, San Diego, San Francisco, and San Jose). Since there were no restrictions on the use of the tobacco settlement agreement funds, local governments could potentially allocate significant funding for local tobacco control activities above and beyond that available to the local health departments through Proposition 99.

Funded by a tobacco excise tax, Proposition 10 was primarily enacted to promote early childhood development; however, it included provisions to fund interventions to encourage pregnant women and parents of young children to quit smoking. Thus the CCF Act provided an opportunity for additional funding for cessation as well as an opportunity for local health departments to partner with new groups that may not have previously been involved in tobacco control activities.

Collaboration in the Development of CX

It was within this context of the enactment of the MSA and CCF Act that CTCP formed a workgroup to design a uniform needs assessment process. The workgroup included representatives from local health departments, ethnic networks, regional community linkage projects, community-based organizations, and voluntary health organizations.

The workgroup's efforts were informed by several local, regional, and national activities, including those from California State University San Bernardino, the American Lung Association of San Diego/Imperial Counties, and the Central Valley Region. Individually, these organizations had identified specific tobacco control benchmarks and were using ratings to compare and contrast progress on each. Similarly, the U.S. Centers for Disease Control and Prevention and others were developing community cardiovascular disease prevention indicators which addressed such factors as the miles of bike trails available in a community.

Simultaneous to CTCP's steps to standardize local tobacco control assessment practices, the American Cancer Society (ACS) embarked on its Communities of Excellence (CX) Initiative. This initiative involved development of a comprehensive tobacco control training tool to guide communities through mobilizing a coalition to developing a local tobacco control strategy. Because of the similarities in the work being done by ACS and CTCP, the two efforts were merged. ACS implemented CX in more than 40 states to promote strong comprehensive tobacco control program planning and development. Evaluation of the CX process in both California and across the nation has shown that local programs using the CX process develop better workplans and more effectively engage local participants in their tobacco control work.

Creation of a Standardized Framework

Prior to the adoption of the CX framework for needs assessments, each agency that was planning tobacco control work would conduct its needs assessments in different ways. Often, these needs assessments were "fishing expeditions" in which the agencies would gather many different kinds of data. There wasn't consistency from one agency to the next in the types of data collected or the way in which the data were coalesced and shared. Thus, the workgroup sought to design a needs assessment which was uniform and yet flexible enough for use in diverse communities which vary greatly in terms of needs, size, barriers, and capacity.

CTCP combined the concepts of community engagement, community indicators, and rating systems to develop the CX needs assessment framework.

Goals

The goals for developing the CX needs assessment framework were to:

- Broaden the involvement of the community in local tobacco control planning;
- Standardize the assessment of community needs and assets across all 61 local health departments;
- Ground the development of the comprehensive tobacco control plan in the needs assessment findings and focus the resulting plans on community norm change versus individual behavior change; and
- Strengthen and improve local program evaluation efforts as a result of using a uniform nomenclature and standardized evaluation requirements.

CX Framework: The Three Legged Stool

The resulting CX needs assessment framework consists of a three-legged stool which supports CTCP's overarching social norm change strategy:

1. Community engagement in assessing needs, prioritizing, and planning.
2. Standardized tobacco control indicators and assets.
3. Uniform needs assessment tools.

<u>Community Engagement in Assessing Needs, Prioritizing, and Planning</u>

CX seeks to engage community members to assess tobacco-related problems using readily available data, set priorities, develop a plan, and then to mobilize the community to activate

the plan. Engagement of the community is an essential element of the CX framework as it brings together a variety of expertise, influence and connections. It gives credibility to program efforts since community members were involved in identifying priorities and developing the plan of action. Additionally, community engagement amplifies the program's messages by multiplying the channels through which messages are promoted, increasing the likelihood that target audiences will come into contact with the messages. Through involvement of the community and its leaders, the community is mobilized to address tobacco-related problems as they are experienced at the community level.

At the heart of CX is the idea that communities can achieve excellence in tobacco control by involving a motivated and diverse group of people to assess where their community is now in terms of tobacco control, determine where it needs to go, and how it will get there.

Local agencies who are leading the CX needs assessment are highly encouraged to develop relationships with and involve groups who are disproportionately affected by tobacco use and/or exposure to secondhand smoke or who have subject matter expertise such as health care providers/systems, schools, law enforcement, business, housing, tourism, environmental groups who may be interested in tobacco waste (e.g., fire prevention and water quality), and others.

Standardized Tobacco Control Indicators and Assets

Indicators

Community indicators represent environmental or community level measures which ask to what extent a certain condition exists in the community. Indicators are focused at the community, organization, or agency level and are observational in nature. They focus on aspects related to tobacco marketing, promotion and distribution; economic factors, secondhand smoke exposure, the environmental impact of tobacco waste, accessibility of tobacco products, and availability of cessation support.

Indicator 2.2.13	**Smoke-free Multi-Unit Housing**: The number of jurisdictions covered by a public policy that prohibits smoking in the individual units of multi-unit housing including balconies and patios.

Assets

Community assets represent factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. They address such things as funding for tobacco control activities, community engagement and inclusivity, capacity building, and cultural competence.

Asset 2.4	**Youth Engagement in Tobacco Control**: The extent our tobacco control program has participatory collaborative partnerships with diverse youth and youth serving organizations and mobilizes their involvement in community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.

Uniform Needs Assessment Tools

The CX needs assessment involves a focused inquiry facilitated by a local agency who engages coalition members, advisory group members and others in rating indicators and assets. The process uses existing local, regional, state, and national data, to discuss the meaning of that data, and then rate how well the community is doing with respect to an indicator or asset. Quantitative data, qualitative data, and the expertise of the community members are taken into consideration and a rubric is used to guide selection of the rating. A consensus rating is recorded on standardized forms along with comments to substantiate the rating. Based on the needs assessment findings, priorities are identified and then a workplan with specific objectives, activities, timelines, responsible parties and evaluation measures is developed.

Evolution of CX

CX was first introduced to local health departments in October 2000 for use in developing their 2001-2004 comprehensive tobacco control plans. While the same assessment framework was used for four local health department plan cycles (2001/04, 2004/07, 2007/10 and 2010/13), the indicators and assets were updated every three years to reflect changes in tobacco control with items being added, modified or retired. California's tobacco control community participates in this triennial process. In 2011, more than 150 recommendations were submitted.

After a decade of using CX in its existing format, CTCP initiated a major revision of the needs assessment tools beginning in 2011. The revision was undertaken in partnership with a workgroup comprised of local health departments and the Tobacco Control Evaluation Center. CTCP conducted an extensive review of the community readiness literature; conducted focus groups and key informant interviews with local health departments, CTCP staff, and external agencies; and pilot-tested the new tools.

Revised CX Framework: The Four Legged Stool

As a result of the revision that began in 2011, a major component was added to the CX needs assessment tool - the Social Disparities Capacity Assessment. This component was added in recognition of tobacco-related disparities by race/ethnicity, socioeconomic status, educational attainment, mental health status, occupation, and geography and the influence of social factors on the use of tobacco. This new fourth leg of the CX stool assesses the use of tobacco-related health disparity data in planning and conducting tobacco control interventions; development of a specific plan of action for reducing tobacco-related disparities; collaborating with community efforts that address social determinants of health; multi-cultural media engagement; and the use of evaluation tools to capture, understand and communicate social and tobacco-related inequities. The four-legged CX stool now consists of:

1. Community engagement in assessing needs, prioritizing, and planning.
2. Rating community capacity to address social disparities.
3. Standardized tobacco control indicators and assets.
4. Uniform needs assessment tools.

Revised CX Framework: Updating the Needs Assessment Tools

Another major change made to the CX needs assessment framework was the revision of the indicator rating forms to assess community readiness for change related to an indicator, stage of change, and quality and reach of adopted legislated policies. The new assessment tools provide more precision. It is anticipated that the resulting needs assessment findings will offer new insights that will improve community readiness and advance sustainable policy/system changes that prevent tobacco use and support cessation interventions.

Conclusion

Since the inception of the CX needs assessment framework in the late 1990s, CTCP has sought to keep the process relevant by updating the CX indicators and assets triennially. CTCP believes that the resulting revisions provide a needs assessment framework that is highly relevant to today's environment and that these tools will help make major progress in reducing tobacco-related disparities. We look forward to the launch of these new tools, hearing about your experiences in using them, and evaluating their usefulness.

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2012 Communities of Excellence Indicators and Assets List

Communities of Excellence Indicators

Priority Area: Limit Tobacco Promoting Influences (1) Tobacco Marketing and Deglamorization Indicators (.1)	
Definition: These indicators address: 1) advertising and marketing tactics used to promote the use of tobacco products and electronic nicotine delivery devices (ENDD), 2) the glamorization of tobacco and ENDD use through entertainment and social media venues, 3) the public image of tobacco and ENDD companies, and 4) other environmental factors that promote tobacco and ENDD product use or that decrease tobacco and ENDD industry influences. The term ENDD refers to any electronic smoking device that delivers nicotine vapor to the user and which is not approved by the Food and Drug Administration as a treatment for nicotine or tobacco dependence, including, but not limited to an electronic cigarette, cigar, cigarillo, hookah or pipe.	
1.1.1	**Store Interior Marketing:** The number of jurisdictions covered by a public policy that restricts or specifically bans time, place, and manner of in-store tobacco and/or ENDD advertising, promotions, or product displays (e.g., "power walls") consistent with the First Amendment and federal law.
1.1.2	**Store Exterior Marketing:** The number of jurisdictions covered by a public policy that restricts or specifically bans time, place, and manner of outdoor store tobacco and/or ENDD advertising or promotions consistent with the First Amendment and federal law.
1.1.3	**Media Outlet Advertising Policies:** The proportion of print and digital media outlets (e.g., magazines, newspapers, social media) that have adopted a voluntary policy to refuse tobacco and/or ENDD advertising.
1.1.4	Retired
1.1.5	**Enforcement of the MSA/STMSA/Federal Tobacco Marketing Restrictions:** The number and type of violations by tobacco manufacturers or retailers for advertising, sponsorship, promotional, or other marketing requirements identified in the Master Settlement Agreement (MSA), the Smokeless Tobacco Master Settlement Agreement (STMSA), or federal law.
1.1.6	**Sponsorship:** The number of jurisdictions covered by a public policy that restricts or specifically bans time, place, and manner of tobacco and/or ENDD company sponsorship and marketing at public, entertainment, and sporting venues (e.g., county fair, rodeo, motor sports, sporting events, parade, concert, museum, dance, festival, business forum) consistent with the First Amendment and federal law.

	Priority Area: Limit Tobacco Promoting Influences (1) Tobacco Marketing and Deglamorization Indicators (.1)
1.1.7	**Adult-Only Facility Marketing:** The number of jurisdictions covered by a public policy that restricts or specifically bans time, place, and manner of tobacco and/or ENDD product marketing and sponsorship at adult-only facilities (e.g., bars and night clubs) consistent with the First Amendment and federal law.
1.1.8	**College/Trade School Marketing:** The number of colleges, universities, trade/technical schools covered by a public policy that restricts tobacco and/or ENDD company product marketing and sponsorship consistent with the First Amendment and federal law.
1.1.9	**Corporate Giving:** The number of professional groups and institutions (e.g., education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, social service) with a voluntary policy that prohibits acceptance of tobacco and/or ENDD-related contributions.
1.1.10	**Political Contributions:** The number of elected officials or political caucuses that have signed a voluntary pledge to refuse tobacco and/or ENDD company contributions.
1.1.11	**Smoking in the Movies:** The number of elected officials, parent organizations, health groups, entertainment entities or other groups that have adopted resolutions and voluntary policies that support: 1) an "R" rating for movies that depict smoking, 2) certifying no payments for depicting tobacco use, 3) an end to the depiction of tobacco brands, 4) requiring the placement of strong anti-smoking ads prior to airing any film with any tobacco presence, and 5) limiting government supported movie subsidies to tobacco-free movies.
1.1.12	**Candy Tobacco Look-Alike Products:** The number of jurisdictions covered by a public policy that prohibits the sale of edible products packaged to resemble tobacco products (e.g., candy cigarettes, bubble gum cigars, chewing gum).
1.1.13	**Anti-Industry Media Coverage:** The number and quality of news media stories, blogs, or social media efforts highlighting the harmful impact of tobacco and/or ENDD industry practices and/or political lobbying on health and/or the environment.
1.1.14	Retired
1.1.15	Retired
1.1.16	Retired
1.1.17	**Anti-tobacco Advertising Placement:** The number of jurisdictions covered by a public policy that mandates a 1:1 or 3:1 placement of anti-tobacco advertising in prime retail locations to counter pro-tobacco and ENDD advertisements, buydowns or other promotional offers consistent with the First Amendment and federal law.
1.1.18	**Advertising on Storefront Windows:** The number of jurisdictions covered by a public policy that restricts the percent of the square footage of windows and clear (e.g., glass) doors of a retailer that may have advertising of any sort, including tobacco.

Priority Area: Limit Tobacco Promoting Influences (1)
Economic Indicators (.2)

Definition: These indictors address financial incentives and disincentives to reduce tobacco and/or electronic nicotine delivery devices (ENDD) industry influences and promote non-tobacco use norms.

The term ENDD refers to any electronic smoking device that delivers nicotine vapor to the user and which is not approved by the Food and Drug Administration as a treatment for nicotine or tobacco dependence, including, but not limited to an electronic cigarette, cigar, cigarillo, hookah or pipe.

1.2.1	**Divestment of Stocks:** The number of public (e.g., county, city or tribal government, public university) and private institutions (e.g., union, private university) with a policy that divests investment in tobacco and/or ENDD stock.
1.2.2	**Health Insurance Discounts for Non-tobacco Users:** The number of public and private employers that offer discounted health insurance premiums to non-tobacco users.
1.2.3	Retired
1.2.4	**Disposal Fee for Toxic Products:** The number of jurisdictions covered by a public policy that imposes an end product producer requirement or fee on tobacco and/or ENDD products, retailers, distributors or manufacturers, with an earmark for tobacco control or litter mitigation activities, in a manner consistent with the requirements of the California Constitution and California law.
1.2.5	**Conflict of Interest:** The number of public (e.g., county, city or tribal government, public university) or privately funded agencies that have a voluntary policy or contract language that prohibits awardees from accepting funding from tobacco and/or ENDD companies during the grant/contract period.
1.2.6	**Minimum Retail Price:** The number of jurisdictions covered by a public policy that sets a minimum retail sale price for tobacco and/or ENDD products or bans or constrains tobacco and/or ENDD industry promotional practices such as buydowns, multi-pack offers, and discounts, consistent with the First Amendment and federal law.
1.2.7	**Minimum Package/Volume Size:** The number of jurisdictions covered by a public policy that establishes a minimum package or volume size for tobacco and/or ENDD products (e.g., cigarettes, cigars, smokeless tobacco, dissolvable tobacco, pipe tobacco, electronic cigarettes) and/or that eliminates the sale and distribution of individual or small unit packages of tobacco and/or ENDD products.
1.2.8	**Healthy Community Incentives:** The number of jurisdictions offering incentives in the form of financial aid, tax credits, technical assistance (e.g., business planning) or other tangible goods and services in exchange for adopting meaningful and sustainable health promoting practices (e.g., building smoke-free multi-unit housing) that support tobacco free living and non-nicotine dependence.
1.2.9	**Healthy Retailer Licensing**: The number of jurisdictions covered by a healthy retailer license that requires minimum health promoting business practices (e.g., minimum standards for limiting tobacco product marketing and advertising, stocking healthy foods, menu information, signage requirements, placement of unhealthy products) and imposes fines, penalties or other sanctions (e.g. suspend WIC or SNAP vendor benefits) for unhealthy activities that occur on the licensed premises (e.g., violations of drug paraphernalia, tobacco, alcohol, and nuisance/loitering laws).

Priority Area: Limit Tobacco Promoting Influences (1) School and Community-based Prevention Indicators (.3)	
Definition: These indicators address the availability and provision of tobacco use prevention education that impacts youths in school and youth serving programs, such as the Scouts or 4-H.	
1.3.1	Retired
1.3.2	Retired
1.3.3	Retired
1.3.4	Retired

Priority Area: Limit Tobacco Promoting Influences (1) Physical Environment Indicators (.4)	
Definition: These indicators address the integration of tobacco-free living elements into community planning, economic development, and redevelopment.	
1.4.1	Retired
1.4.2	Retired
1.4.3	**General Plan:** The number of jurisdictions that include tobacco-free living health promotion elements in the General Plan.

Priority Area: Limit Tobacco Promoting Influences (1) Global Movement Indicators (.5)	
Definition: These indicators address countering the national and international promotion and distribution of tobacco electronic nicotine delivery device (ENDD) products and in other states and countries. The term ENDD refers to any electronic smoking device that delivers nicotine vapor to the user and which is not approved by the Food and Drug Administration as a treatment for nicotine or tobacco dependence, including, but not limited to an electronic cigarette, cigar, cigarillo, hookah or pipe.	
1.5.1	**International Marketing Accountability:** The number of local resolutions in support of policies to hold U.S. tobacco and ENDD companies accountable for consistent tobacco and ENDD marketing and product distribution standards across their U.S. and international business operations.
1.5.2	Retired
1.5.3	Retired
1.5.4	Retired

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
Definition: These indicators address the impact of tobacco use on people, other living organisms, and the physical environment resulting from exposure to: 1) secondhand smoke, 2) tobacco smoke residue, 3) tobacco waste, and 4) tobacco products. The terms "smoke" and "smoking" are intended to cover the use of electronic nicotine delivery devices (ENDD). The term ENDD refers to any electronic smoking device that delivers nicotine vapor to the user and which is not approved by the Food and Drug Administration as a treatment for nicotine or tobacco dependence, including, but not limited to an electronic cigarette, cigar, cigarillo, hookah or pipe. The terms "smoke-free" and "tobacco-free" are not intended to apply to ceremonial, sacred or religious uses of tobacco products.	
2.2.1	**Household Smoking:** The proportion of households with a voluntary policy that does not permit smoking in the home (e.g., single dwelling house, mobile home, apartment, boat).
2.2.2	Retired
2.2.3	**American Indian Smoke-free Worksites (Non-Gaming Worksites):** The number of American Indian tribal governments with a public policy that designates indoor worksites as smoke-free, not including casino/leisure complexes (Note: Smoke-free policies do not apply to ceremonial, religious or sacred use of tobacco products).
2.2.4	**Labor Code 6404.5 Exemptions:** The number of jurisdictions covered by a public policy that prohibits indoor worksite smoking in those areas that are exempted by the state smoke-free workplace law (e.g., 5 or fewer employees, warehouses, owner operated bars, tobacco shops, hotel lobbies, hotel guest rooms).
2.2.5	Retired
2.2.6	**Smoke-free Outdoor Dining/Bars/Service Areas:** The number of jurisdictions covered by a public policy that designates the outdoor dining, beverage, and service areas of restaurants, bars, nightclubs, and mobile catering businesses as smoke-free.
2.2.7	**Smoke-free Outdoor Worksites:** The number of jurisdictions covered by a public policy that designates outdoor worksite premises as smoke-free (e.g., construction sites, logging operations, fishing operations). Note: do not use this indicator, if the worksite is addressed by one of the following indicators: outdoor dining areas (2.2.6), non-recreational outdoor public areas (2.2.9), health care campuses (2.2.10), outdoor recreational areas (2.2.16), K-12 schools (2.2.17), faith community campuses (2.2.20), and commercial or non-profit child care facility premises (2.2.27).
2.2.8	**Smoke-free Doorways:** The number of jurisdictions covered by a public policy that prohibits smoking within 20 feet or more of all doorways, windows, vents, and openings of public and private worksites.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.9	**Smoke-free Outdoor Non-recreational Public Areas:** The number of jurisdictions covered by a public policy that designates outdoor non-recreational public areas as smoke-free (e.g., walkways, streets, plazas, college/trade school campuses, shopping centers, transit stops, farmers markets, swap meets). Note: do not use this indicator, if the outdoor non-recreational public area is addressed by one of the following indicators: health care campuses (2.2.10), K-12 schools (2.2.17), faith community campuses (2.2.20), and commercial or non-profit child care facility premises (2.2.27).
2.2.10	**Smoke-free Health Care Campuses:** The number of jurisdictions covered by a public policy that designates indoor and outdoor premises of licensed health care and/or assisted living facilities (e.g., hospitals, other acute health care facilities, drug and rehab facilities, mental health facilities, adult day care or residential facilities, social rehabilitation facilities, adult group homes, assisted living facilities, skilled nursing facilities, doctors' offices) as smoke-free at all times.
2.2.11	Retired
2.2.12	Retired
2.2.13	**Smoke-free Multi-Unit Housing**: The number of jurisdictions covered by a public policy that prohibits smoking in the individual units of multi-unit housing including balconies and patios.
2.2.14	Retired
2.2.15	Retired
2.2.16	**Smoke-free Outdoor Recreational Areas:** The number of jurisdictions covered by a public policy that designates outdoor recreational facilities, areas, and venues as smoke-free (e.g. amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sporting venues, tot lots, zoos).
2.2.17	**Tobacco-free Schools:** The number of public and private kindergarten, elementary, middle, and high schools that designate their campuses as tobacco-free inside and outside at all times.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.18	**Smoke-free Licensed Home Childcare and Foster Homes:** The number of jurisdictions covered by a public policy that requires licensed home childcare and foster homes to be completely smoke-free and/or tobacco-free everywhere, inside and outside at all times.
2.2.19	Retired
2.2.20	**Smoke-free Faith Community Campuses:** The number of faith community organizations (e.g., churches, synagogues, mosques, temples) with a voluntary policy that designates outdoor areas as smoke-free except when tobacco is used for ceremonial or religious purposes.
2.2.21	Retired
2.2.22	**Tobacco Control Elements in General Plans/Building Codes/Zoning Requirements:** The number of jurisdictions that use zoning regulations, building codes, housing or other general plan elements, Housing and Urban Development consolidated plans, permitting processes, etc. to increase the amount of smoke-free indoor or outdoor areas in multi-unit housing.
2.2.23	**Multi-Unit Housing Smoking Disclosure:** The number of jurisdictions covered by a public policy that requires multi-unit housing complexes to disclose the location of smoking and nonsmoking units, the smoking history of a unit, and/or require rental vacancy listings to include a category for smoking and nonsmoking units.
2.2.24	**Secondhand Smoke Designated as a Nuisance:** The number of jurisdictions covered by a public policy declaring non-consensual exposure to secondhand smoke as a nuisance.
2.2.25	**American Indian Smoke-free Gaming:** The number of American Indian/tribal owned casino/leisure complexes with a policy that designates all indoor areas of casino/leisure complexes as smoke-free, excluding when tobacco is used for ceremonial, religious or sacred purposes.
2.2.26	**Smoke-free Common Areas of Multi-Unit Housing:** The number of jurisdictions covered by a public policy that designates common indoor (e.g., laundry room, hallways, stairways, and lobby) and outdoor (e.g., playground, swimming pool area, entrances) areas of multi-unit housing complexes as smoke-free.
2.2.27	**Smoke-free Licensed Day and Residential Care:** The number of jurisdictions covered by a public policy that designates commercial and non-profit licensed childcare centers and children's residential facilities (e.g., crisis nurseries, youth group homes, transitional living centers) as smoke-free and/or tobacco-free everywhere, inside and outside at all times.
2.2.28	**Smokeless Tobacco and E-cigarette Use:** The number of jurisdictions covered by a public policy that prohibits the use of non-combustible tobacco products (e.g., smokeless tobacco products, dissolvable tobacco products) and/or nicotine products that are not specifically approved by the Food and Drug Administration (FDA) for use in treating nicotine or tobacco dependence (e.g., electronic nicotine vaporization devices) in places where smoking is otherwise prohibited.

Priority Area: Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products (2) Policy Indicators (.2)	
2.2.29	**Tobacco Litter:** The number of jurisdictions covered by a public policy to reduce tobacco litter in public places (e.g., parks, playgrounds, beaches) and water systems.
2.2.30	**Tobacco Product Litter Audit:** The number of jurisdictions covered by a public policy that requires a tobacco product litter cost assessment.

Priority Area: Reduce the Availability of Tobacco (3) Policy Indicators (.2)	
Definition: These indicators address the sale, distribution, sampling, or furnishing of tobacco products and electronic nicotine delivery devices (ENDD). The term ENDD refers to any electronic smoking device that delivers nicotine vapor to the user and which is not approved by the Food and Drug Administration as a treatment for nicotine or tobacco dependence, including, but not limited to an electronic cigarette, cigar, cigarillo, hookah or pipe.	
3.2.1	**Tobacco Retail Licensing:** The number of jurisdictions covered by a tobacco and/or ENDD retail licensing policy that earmarks a portion of the license fee for enforcement activities.
3.2.2	**Tobacco Retailer Density/Zoning:** The number of jurisdictions covered by a policy that restricts the number, location, and/or density of tobacco and/or ENDD retail outlets through use of any of the following means: conditional use permits, zoning, tobacco retail permits or licenses, or direct regulation.
3.2.3	Retired
3.2.4	**Tobacco Industry Sampling, Coupons/Discounts/Gifts:** The number of jurisdictions covered by a public policy that restricts the distribution of free or low-cost tobacco and ENDD products, and/or restricts the distribution and/or redemption of coupons, coupon offers, gift certificates, gift cards, rebate offers or other similar offers for tobacco and ENDD products consistent with the First Amendment and federal law.
3.2.5	Retired
3.2.6	Retired
3.2.7	**Tobacco-free Pharmacies and Health Care Providers:** The number of jurisdictions covered by a public policy that eliminates the sale and distribution of tobacco and/or ENDD products from places where pharmacy and/or other health care services are provided by a licensed health care professional (e.g., hospital, vision screening, blood pressure screening).
3.2.8	Retired

Priority Area: Reduce the Availability of Tobacco (3) Policy Indicators (.2)	
3.2.9	**Menthol and Other Flavored Tobacco Products:** The number of jurisdictions covered by a public policy that eliminates the sale and distribution of mentholated cigarettes and/or other flavored tobacco and ENDD products (e.g., smokeless tobacco products, dissolvable tobacco products, non-premium cigars such little cigars, cigarillos, hookah tobacco, e-cigarettes, e-hookah).
3.2.10	Retired
3.2.11	**Electronic Nicotine Delivery Devices:** The number of jurisdictions covered by a public policy that eliminates the sale or distribution of tobacco products and electronic nicotine vaporization devices including electronic cigarettes, electronic pipes, electronic cigars, and electronic hookahs.
3.2.12	**Tobacco Product Definition:** The number of jurisdictions covered by a public policy that broadly defines "tobacco product" to include cigarettes, smokeless tobacco, cigars, pipe tobacco, hookah tobacco and any product containing nicotine or any product used to introduce nicotine into the body, including but not limited to such things as dissolvable tobacco products and electronic nicotine vaporization devices (e.g., cigarettes, electronic pipes, electronic cigars, electronic hookah), but excluding products specifically approved by the FDA for use in treating nicotine or tobacco dependence.

Priority Area: Reduce the Availability of Tobacco (3) Behavior Indicators (.3)	
Definition: These indicators address the sale, distribution, sampling, or furnishing of tobacco products and other nicotine containing products that are not specifically approved by the Food and Drug Administration (FDA) as a treatment for nicotine or tobacco dependence (e.g. social sources of tobacco, shoulder tapping).	
3.3.1	Retired

Priority Area: Promote Tobacco Cessation (4) Cessation Service Indicators (.1)	
Definition: These indicators address the direct provision of culturally and linguistically appropriate cessation services and nicotine replacement therapy distribution which is not provided as part of a health insurance benefit.	
4.1.1	**Tobacco Cessation Services:** The extent to which evidence-based and culturally and linguistically appropriate behavior modification-based tobacco cessation services are available in the community.
4.1.2	Retired
4.1.3	**Cessation Pharmacotherapy:** The extent to which evidence-based free or low cost pharmacological quitting aids are available to tobacco users who are not eligible for a cessation pharmacological benefit through a government or employer subsidized health insurance plan.
4.1.4	**Cessation Assessment and Referral Systems:** The extent to which health care, social service, and education agencies systematically refer patients and clients to accessible, evidence-based tobacco cessation programs such as the California Smokers' Helpline.

Priority Area: Promote Tobacco Cessation (4) Policy Indicators (.2)	
Definition: These indicators address the availability of behavior modification and cessation pharmacotherapy services provided through health care plans, the health care system, and employers.	
4.2.1	**Health Insurance Coverage for Cessation Benefits:** The extent to which health insurance plans provide comprehensive coverage of tobacco dependence treatments with few or no barriers to access, consistent with the U.S. Public Health Service Clinical Practice Guidelines, Treating Tobacco Use and Dependence (2008 Update).
4.2.2	**Health Care System Tobacco User Identification and Treatment Systems:** The number of health care clinics that implement a tobacco user identification system, provide education, resources, and feedback to promote provider intervention, and dedicate staff to provide cessation treatment, consistent with the U.S. Public Health Service Clinical Practice Guidelines, Treating Tobacco Use and Dependence (2008 Update).
4.2.3	Moved. See indicator 2.2.28
4.2.4	**Behavioral Health Cessation Treatment Programs:** The number of alcohol and drug treatment programs, mental health treatment programs, migrant clinics, and other health or social service agencies that have systematically implemented evidence-based tobacco cessation treatment, consistent with the U.S. Public Health Service Clinical Practice Guidelines, Treating Tobacco Use and Dependence (2008 Update).

	Priority Area: Promote Tobacco Cessation (4) Policy Indicators (.2)
4.2.5	**Employer-based Cessation Programs:** The number of employers that have adopted a comprehensive plan to promote tobacco cessation among their employees, including covering multiple evidence-based treatments, promoting awareness of these benefits and of the importance of quitting, and providing financial incentives for employees' use of cessation services.
4.2.6	**Hospital-based Cessation Treatment and Follow-up:** The number of hospitals that have implemented the 2012 Joint Commission Tobacco Treatment Measures, including screening inpatients for tobacco use, providing evidence-based cessation treatment during the hospital stay and a discharge, and assessing tobacco use status post-discharge.
4.2.7	**Electronic Medical Records:** The number of health care practices and organizations that have implemented tobacco cessation into their electronic medical record (EMR) systems consistent with federal "Meaningful Use" guidelines (i.e., EMR use achieves significant improvements in care).
4.2.8	**Nicotine Addiction Treatment Incorporated into Health Care Professional Curricula:** The number of medical, nursing, dental, pharmacy, and other allied health professional schools that include training on the treatment of nicotine or tobacco dependence in their curricula.

Communities of Excellence Assets

Tobacco Control Funding Assets (1)	
Definition: These assets address the availability of funding to support tobacco control efforts.	
1.1	**Tobacco Control Funding:** Global per capita appropriation for tobacco control activities, from various sources, is consistent with the recommendations of the National Association of County and City Health Officials: • <100,000 population: $8-$10/capita; • 100,000-500,001 population:$6-$8/capita; • >500,001 population: $4-$6/capita. Subset of Global per capita funding for school programs: • $4-$6 per student regardless of student population size.
1.2	**Master Settlement Agreement (MSA) Funding:** The amount of MSA funds that are appropriated for the purpose of tobacco control activities.
1.3	**Proposition 10 Funding:** The amount of local Proposition 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children.
1.4	**Affordable Care Act Community Health Needs Assessment Participation:** The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act* for the purpose of promoting the inclusion of indicators and interventions that support tobacco-free living (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement and advocacy, workforce development, other community development activities to build health and safety). *SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011.

Social Capital Assets (2)	
Definition: These assets address the extent to which people and organizations work collaboratively in an atmosphere of trust to accomplish goals of mutual interest.	
2.1	**Training and Skill Building:** The extent training and technical assistance are available to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.
2.2	**Coalition/Advisory Committee Satisfaction:** The extent of satisfaction among coalition or advisory committee members with program planning, involvement of the community, implementation activities, quality of services, and progress made by the project.
2.3	**Key Opinion Leader Support:** The extent of support among local key opinion leaders for tobacco-related community norm change strategies.

	Social Capital Assets (2)
2.4	**Youth Engagement in Tobacco Control:** The extent our tobacco control program has participatory collaborative partnerships with diverse youth and youth serving organizations and mobilizes their involvement in community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.
2.5	**Adult Engagement in Tobacco Control:** The extent our tobacco control program has participatory collaborative partnerships with diverse adults and non-Proposition 99 funded adult serving organizations and mobilizes their involvement in community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.
2.6	Retired and integrated with 2.5
2.7	Retired and integrated with 2.5

	Cultural Diversity and Cultural Competency (3)
Definition: These assets address behaviors, attitudes, and policies that enable effective work in cross-cultural situations within the work environment and community. Culture refers to patterns of human behavior that include the languages, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, sexual orientation, or social groups. Competency refers to having the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and the community.	
3.1	**Coalition/Advisory Committee Diversity:** The extent our tobacco control program has built and engages a diverse coalition or advisory committee in designing and implementing tobacco control activities. Diversity is inclusive of ethnicity, culture, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).
3.2	Retired
3.3	**Cultural Competence Assessment:** The extent our tobacco control program periodically conducts self-assessments of organizational cultural competence.
3.4	**Tailored Educational and Outreach Materials:** The extent our tobacco control program makes culturally appropriate educational, outreach and media materials easily available and appropriate for the languages and literacy levels of commonly encountered groups in the service area.
3.5	Retired
3.6	**Equity in Funding:** The extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.
3.7	Retired

Social Disparities Capacity Assessment Instructions

Background

The California Tobacco Control Program (CTCP) has successfully reduced the smoking prevalence of Californians across all demographic groups. However, large differences in smoking prevalence persist among population groups by race/ethnicity, socioeconomic status, educational attainment, occupation, mental health status, sexual orientation, and geography. These groups, called priority populations, have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are more targeted by the tobacco industry, and have higher rates of tobacco-related disease compared to the general population. As a result, they suffer disproportionately from tobacco-related death and disease.

These differences in tobacco use prevalence and disproportionate rates of tobacco-related death and disease among priority population groups are known as health or social disparities. CTCP is committed to accelerating the rate of change in priority population groups disproportionately impacted by tobacco use and secondhand smoke exposure, and to eliminating tobacco-related disparities.

The Communities of Excellence in Tobacco Control (CX) planning framework helps agencies to systematically assess their communities and then to design tobacco control plans that focus on substantive, long-lasting social norm change in order to reduce tobacco use and exposure to secondhand smoke. To reduce tobacco-related disparities, it is vitally important that tobacco control interventions reach the populations most impacted by tobacco use. Current social norms in California which exacerbate tobacco-related health disparities include: exemptions in clean indoor air workplace policies which permit smoking in small businesses, hotel lobbies, banquet rooms, skilled nursing facilities, cabs of work trucks, and tobacco-retail only shops; permissive smoking policies within tribal gaming facilities and worksites; a lack of full health insurance coverage for tobacco cessation counseling and pharmaceutical support; a lack of robust and multilingual mass-reach health communication campaigns; tobacco pricing policies that support ready access to low-cost cigarettes and other tobacco products; and saturation of environments with tobacco marketing, particularly in low income and African American neighborhoods.

Addressing these and other social norms which promote tobacco use requires that we engage priority population communities in a manner that is effective and relevant. Doing so requires becoming familiar with these communities, including their specific cultural, linguistic, and social characteristics. It also requires developing an understanding of strategies for addressing the interconnectedness between tobacco use and other social and environmental issues. The Social Disparities Capacity Assessment is designed to help agencies: 1) review how tobacco use impacts priority populations in their community, 2) identify program strengths which can be leveraged, and 3) identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

Cover Page

1. **Community Area(s) Assessed:** Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a county wide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are four types of drop down menus for communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) Indian tribal lands.

2. **Completion Date:** Identify the month, day, and year your agency completed the Social Disparities Capacity Assessment.

   OTIS: A calendar is provided in OTIS to select the date.

3. **Data Sources, References & Citations:** Use local, regional, state, and/or national data to assess the item. List the title and year of data sources used in the assessment. Qualitative data sources, such as key informant interviews, focus group findings, and coalition discussions are acceptable data sources.

   OTIS: A drop down menu of common data sources is in OTIS, but you are encouraged to identify additional local data or other references and citations.

4. **Who completed the assessment?** List the coalition name, organization names, or the names of individuals who reviewed data, discussed, and completed the Social Disparities Capacity Assessment.

5. **Record Keeping:** For audit and record keeping purposes it is recommended that you maintain a file with the data documents used to complete the Social Disparities Capacity Assessment along with the completed worksheet. Do not submit these documents to CTCP.

Social Disparities Capacity Rating - Worksheet A

Purpose: The Social Disparities Capacity Assessment should be used to: 1) inform how you are reaching priority populations in your tobacco control work, 2) identify strengths you can leverage in scope of work activities to address tobacco-related disparities, and 3) identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

1. **Assessment and Rating Process:** The Social Disparities Capacity Assessment should be based on your coalition's knowledge of Social Disparities within your community and a discussion of relevant quantitative and qualitative data reviewed. Refer to the Social Disparities Capacity Rating Rubric to help guide the discussion. In addition to completing the rating for each item on the worksheet, you will write a brief narrative summary (limited to 500 words) which describes the program's overall strengths and weaknesses in relation to the five items that make up the Social Disparities Capacity Assessment.

2. **Social Disparities Capacity Assessment Measure:** The Social Disparities Capacity Measure is composed of 5 items: 1) Tobacco-related Data Profile, 2) Tobacco Disparity Strategic Plan, 3) Social Determinants of Health Considerations, 4) Media Engagement, and 5) Evaluation Inclusion.

3. **Rating Scale:** Each item is rated on a six point (0 to 5) Likert scale of *Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree, Agree, and Strongly Agree*. Check the most appropriate rating in response to each item.

4. **Rating Rubric:** The *Social Disparities Capacity Rating Rubric* provides a general description for each item on the Likert scale. Refer to it to help you select the most appropriate rating for each of the 5 items on the Social Disparities Capacity Rating Worksheet.

5. **Capacity to Address Social Disparities Score:** To facilitate comparisons, the ratings given to each item on the Social Disparities Capacity Assessment will be converted into a "score."

   OTIS: OTIS will automatically calculate the Social Disparities Capacity Assessment score once the data are entered and saved.

   If not using OTIS: To manually calculate the Social Disparities Capacity Assessment Score use the formula provided at the bottom of the Worksheet A, Box A-1.

   - Sum the individual ratings.
   - Divide the sum by the total possible score (25).
   - Multiple by the results by 100 and display the score as a percentage.

   Example: If the rating for the Social Disparities items totaled 20, the score would be 20÷25×100=80%.

6. **Narrative Summary:** Complete the Social Disparities Capacity Assessment Narrative Summary (limited to 500 words) to describe the program's strengths and weaknesses in relation to the five items assessed above. Make sure that the description helps to substantiate the rating given to each of the five items.

7. **CX Needs Assessment Overview Report - Worksheet I:** Transfer the individual ratings and score from the Social Disparities Capacity Assessment to Worksheet I to manually create a report that summarizes your assessment conclusions.

   OTIS: This report will be created automatically in OTIS once data from the Social Disparities Capacity Rating Worksheet are entered and saved in OTIS.

Social Disparities Capacity Assessment Cover Page

Social Disparities Capacity Assessment Cover Page

Community Area(s) Assessed:

Social Disparities Capacity Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Social Disparities Capacity Assessment rating? (Title and Year)

Who was engaged in discussing and completing the Social Disparities Capacity Assessment rating? (List the coalition name, organizational names, or the names of individuals.)

Social Disparities Capacity Assessment Rating - Worksheet A

Instructions: Please indicate your level of agreement with each of the 5 items below.

	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
1. **Tobacco-related Data Profile.** Our tobacco control program maintains a current demographic and epidemiological profile of the community to prioritize, plan, and implement activities to reduce tobacco-related health disparities in a culturally and linguistically appropriate manner.	☐	☐	☐	☐	☐	☐
2. **Tobacco Disparity Strategic Plan.** Our tobacco control program has a written strategic plan that outlines a vision, clear objectives and strategies to reduce tobacco-related disparities in a culturally and linguistically appropriate manner within the service area.	☐	☐	☐	☐	☐	☐

	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
3. **Social Determinants of Health Considerations.** Our tobacco control program collaborates with community programs that address the following SDOH factors that may contribute to tobacco-related health disparities: • Availability of quality housing • Community safety and violence prevention • Recreation opportunities, parks and open space • Land use planning • Quality public education • Community economic development (e.g., job creation, business development) • Racial / socail injustice • Arts and culture • Transportation planning and availability • Environmental justice • Food security • Early childhood development and education • Youth development and leadership.	☐	☐	☐	☐	☐	☐
4. **Media Engagement.*** Our tobacco control program regularly works with multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area. *Media Engagement includes both paid and earned media.	☐	☐	☐	☐	☐	☐

	Strongly Disagree (0)	Somewhat Disagree (1)	Neither Agree nor Disagree (2)	Somewhat Agree (3)	Agree (4)	Strongly Agree (5)
5. **Evaluation Inclusion.** Our tobacco control program routinely collects data that can be used to communicate and understand social inequities in health including using methods such as photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.	☐	☐	☐	☐	☐	☐

Box A- 1

Social Disparities Capacity Assessment Score:	Add lines 1 through 5		x	$\frac{100}{25}$	=		%

Social Disparities Capacity Assessment Narrative Summary: Overall, describe the program's strengths and weaknesses in relation to the 5 items assessed. (limited to 500 words.)

Social Disparities Capacity Assessment Rating Rubric

Worksheet A

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
1. **Tobacco-related Data Profile.** Our tobacco control program maintains a current demographic and epidemiological profile of the community to prioritize, plan and implement activities to reduce tobacco-related health disparities in a culturally and linguistically appropriate manner.	Our tobacco control program **never reviews and uses** demographic and epidemiological data for priority setting, planning, and implementation activities.	Our tobacco control program **rarely reviews and uses** demographic and epidemiological data for priority setting, planning, and implementation activities.	Our tobacco control program **occasionally reviews and incorporates** demographic and epidemiological data into priority setting, planning, and implementation activities.	Our tobacco control program **frequently reviews** demographic and epidemiological data and **incorporates** these data into priority setting, planning, and implementation activities.	Our tobacco control program **regularly seeks out** demographic and epidemiological data and **usually incorporates** these data into priority setting, planning, and implementation activities.	Our tobacco control program **actively collects, maintains, and tracks** a core data set that comprises a Tobacco-related Data Profile for our service area and **always incorporates** these data into priority setting, planning, and implementation activities.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
2. **Tobacco Disparity Strategic Plan.** Our tobacco control program has a written strategic plan that outlines a vision, clear objectives and strategies* to reduce tobacco-related disparities in a culturally and linguistically appropriate manner within the service area. *Strategies addressed by the plan include: 1. Improve data collection and analyses to identify disparities and drive interventions. 2. Increase awareness among disparately impacted populations regarding the impact of tobacco use and secondhand smoke exposure. 3. Integrate representatives of disparate populations in key decision-making bodies and processes. 4. Reduce the impact of tobacco industry targeting of diverse populations through policy, environmental, and system changes.	Our tobacco control program **does not have** a tobacco-specific disparity plan -or- a chronic disease disparity strategic plan.	Our tobacco control program **does not have** a tobacco-specific disparity strategic plan, -but- our agency has a **non-tobacco specific** chronic disease disparity strategic plan.	Our tobacco control program **has** a tobacco-specific disparity strategic plan that is **more than 3 years old.**	Our tobacco control program **has** a tobacco-specific disparity strategic plan that was **prepared within the last 3 years,** -but- it **does not address each of the four strategies*.**	Our tobacco control program **has** a tobacco-specific disparity strategic plan that was **prepared within the last 3 years,** that **addresses each of the four strategies*,** -but- it **has been minimally implemented.**	Our tobacco control program **has** a tobacco-specific disparity strategic plan that was **prepared within the last 3 years,** that **addresses each of the four strategies*** -and- it is **actively being implemented and evaluated** across all elements.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
3. **Social Determinants of Health (SDOH) Considerations[1, 2].** Our tobacco control program collaborates with community programs that address the following SDOH factors that may contribute to tobacco-related health disparities: • Availability of quality housing • Community safety and violence prevention • Recreation opportunities, parks and open space • Land use planning • Quality public education • Community economic development (e.g., job creation, business development) • Racial/social injustice • Arts and culture • Transportation planning and availability • Environmental justice • Food security • Early childhood development and education • Youth development and leadership.	In the past three years, our tobacco control program has collaborated with community programs that address **3 or fewer** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 4** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 6** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 8** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **at least 10** SDOH factors that may contribute to tobacco-related health disparities.	In the past three years, our tobacco control program has collaborated with community programs that address **more than 10** SDOH factors that may contribute to tobacco-related health disparities.

[1] SDOH shape the choices that people make every day, as well as the opportunities and resources for health available to them. People in disadvantaged communities often have few opportunities and resources for health, which is reflected in significantly worse health outcomes.

[2] Question is adapted from Bay Area Regional Health Inequities Initiative. *Local health department organizational self-assessment for addressing health inequities*. Oakland, CA, 2010

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
4. **Media Engagement*.** Our tobacco control program regularly works with multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area. *Media Engagement includes both paid and earned media.	Our tobacco control program **never** engages multi-cultural media through traditional or social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least 1 time per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least 2 times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least 4 times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least 6 times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.	**At least 8 times per year**, our tobacco control program engages multi-cultural media through traditional and social media channels to raise awareness about the impact of tobacco use on diverse populations in our service area.

Social Disparities Question	Strongly Disagree 0	Somewhat Disagree 1	Neither Agree nor Disagree 2	Somewhat Agree 3	Agree 4	Strongly Agree 5
5. **Evaluation Inclusion.** Our tobacco control program routinely collects data that can be used to communicate and understand social inequities in health including using methods such as: photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.	Our tobacco control program **never** collects data that can be used to communicate and understand **social inequities** in health including using methods such as: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)	**At least 1 time per year**, our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **1** of the following methods: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)	**At least 2 times per year**, our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **2** of the following methods: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)	**At least 2 times per year**, our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **3** of the following methods: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)	**At least 2 times per year**, our tobacco control program collects and discusses data that can be used to communicate and understand **social inequities** in health including using **4** of the following methods: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)	**At least 2 times per year**, our tobacco control program collects and discuses data that can be used to communicate and understand **social inequities** in health including using **5** or more of the following methods: (photovoice, digital story-telling, key informant interviews, focus groups, listening sessions, and demographics analysis.)

Indicator Assessment Instructions

Background

The Indicator Assessment consists of two parts: 1) rating **Community Readiness** (Worksheet B); and 2) rating **Policy/System Status** (Worksheets C, D, and E). Each indicator will be reviewed and rated based on these two assessments.

To facilitate comparisons of the ratings, the ratings will be converted into "scores" and a **Total Indicator Score** (Worksheet F) will be generated for each indicator. Figure 2 illustrates the individual assessments that will comprise the Total Indicator Score.

In addition to completing the rating worksheets, you will write a narrative summary (Worksheet G). The narrative summary provides information to support the individual assessment ratings and the resulting Total Indicator Score.

Table 1, *Summary of Indicator Worksheets*, provides a brief description of the worksheets you will use to rate each indicator, manually calculate the overall indicator score, and manually record key information from the indicator assessment onto an overview report.

Figure 2. Total Indicator Score

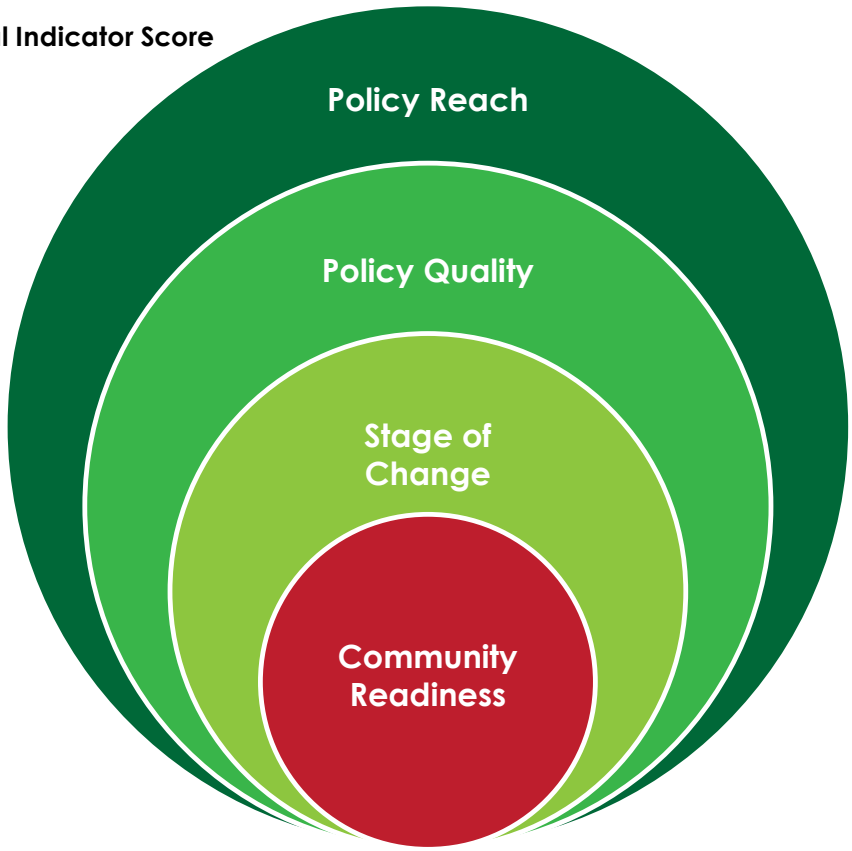

Table 1. Summary Indicator Worksheets

Summary of Indicator Worksheets		
Worksheet	**Title**	**Description**
Worksheet B	Community Readiness	This assessment describes the community's readiness to work on a policy or system change in terms of a) adopting a change, b) implementing a change, or c) facilitating acceptance and compliance with a change.
Worksheet C	Stage of Change	This assessment describes the stage of change that a community is at along a six stage change continuum.
Worksheet D	Policy Quality	This assessment describes the quality of legislated policies against a pre-defined public health quality standard.
Worksheet E	Policy Reach	This assessment describes the proportion of the population within the local health jurisdiction that is protected by a specific legislated policy.
Worksheet F	Total Indicator Score	This worksheet will help you manually calculate preliminary indicator scores prior to entering assessment findings into OTIS. Once data are entered and saved into OTIS, these scores will be automatically generated in OTIS.
Worksheet G	Indicator Narrative Summary	This worksheet narratively summarizes quantitative and qualitative information which explains and supports the Community Readiness and Policy/System Status scores.
Worksheet I	Needs Assessment Overview Report	This worksheet helps to organize all of the ratings, scores, and narrative explanations from your CX needs assessment from the Social Disparities Capacity Assessment, Indicator Assessment (Community Readiness, Stage of Change, Policy Quality, Policy Reach), and the Asset Assessment prior to entering the assessment information into OTIS. Once data are entered and saved into OTIS, this report will be automatically created in OTIS.

Community Readiness - Worksheet B

This assessment describes the community's readiness to work on a policy or system change in terms of a) adopting a change, b) implementing a change, or c) facilitating acceptance and compliance with a change. The Community Readiness assessment consists of the five items listed below. Each of these items is rated on a six point (0 to 5) Likert scale of *None, Poor, Fair, Good, Very Good, and Excellent.*

1. Scope of the Problem
2. Community Awareness
3. Community Support
4. Decision Maker Support
5. Earned Media

Policy/System Status

This assessment describes the status of tobacco-related policy and systems within the community. It consists of three measures: 1) Stage of Change, 2) Policy Quality, and 3) Policy Reach. Each of these measures is rated on a six item continuum.

1. Stage of Change - Worksheet C

This assessment describes the stage of change that a community is at along a six stage change continuum: *No Formal Activities, Planning/Advocating, Policy/System Change Proposed, Policy/System Change Adopted, Policy Implemented, and Compliance/ Enforcement.*

2. Policy Quality - Worksheet D

This assessment describes the quality of **legislated policies** against a pre-defined public health quality standard.[1] This standard was established for legislated policies adopted by a county board of supervisors or city council for the following types of policies:

- Tobacco Retail Licensing (TRL)
- Multi-Unit Housing (MUH)
- Outdoor Secondhand Smoke (SHS)
- Tobacco Sampling

The Quality Rating will be calculated for the entire local health jurisdiction by CTCP for TRL, MUH, Outdoor SHS, and Tobacco Sampling ordinances.

- The Quality Rating is a composite rating for the entire health jurisdiction. It is computed by calculating the quality rating for each ordinance adopted within the local health jurisdiction, summing the individual quality ratings for "like" types of ordinances and then dividing the sum by the total number of jurisdictions in the local health jurisdiction.
- A zero will be assigned for indicators that have no CTCP-assigned quality rating (e.g., legislated policies not rated by CTCP, voluntary policies, resolutions, and systems changes).

3. Policy Reach - Worksheet E

This assessment describes the proportion of the population within the local health jurisdiction that is protected by a specific legislated policy. A local health jurisdiction-wide Reach Rating will be calculated by CTCP for TRL, MUH, Outdoor SHS, and Tobacco Sampling legislated policies.

- The Reach Rating is calculated by summing the populations of the jurisdictions where a legislated policy has been enacted and then dividing the sum by the total population of the local health jurisdiction (i.e., county population or city population for Berkeley, Long Beach, and Pasadena).

[1] The standard was created by the California Tobacco Control Program, California Department of Public Health (CTCP,CDPH) as a result of reviewing the literature, and working with ChangeLab Solutions, and local, state and national public health practitioners.

- A zero will be assigned for indicators that have no CTCP-assigned reach rating (e.g., legislated policies not rated by CTCP, voluntary policies, resolutions, and systems changes).

Table 2, *Summary of Indicator Rating Data*, summarizes the source of the rating information for different types of policy and system changes.

Table 2. Summary of Indicator Rating Data

	Policy/System Status			
Type of Policy/System Change	**Community Readiness**	**Stage of Change**	**Policy Quality**	**Policy Reach**
MUH Ordinance	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
Outdoor SHS Ordinance	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
TRL Ordinance	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
Tobacco Sampling Ordinance	Coalition Rates	Coalition Rates	CTCP Provides Composite Rating	CTCP Provides Composite Rating
Other Ordinances	Coalition Rates	Coalition Rates	0	0
Voluntary Policy	Coalition Rates	Coalition Rates	0	0
Resolution	Coalition Rates	Coalition Rates	0	0
System Change	Coalition Rates	Coalition Rates	0	0

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1. **Indicator Number and Title**: List the indicator number and brief title.

   OTIS: A drop down menu is provided in the Online Tobacco Information System (OTIS).

2. **Core Indicator**: A "core" indicator is one that every agency must assess. Refer to the funding guidelines for a list of the core indicators. Indicate "yes" if the indicator is listed as a core indicator. Indicate "no" if it is not listed as a "core" indicator in the funding guidelines.

   OTIS: In OTIS, this field will be pre-populated.

3. **Community Area (s) Assessed**: Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a countywide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are drop down menus for four types of communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) Indian tribal lands.

4. **Completion Date**: Identify the month, day, and year your agency completed the Indicator Assessment.

   OTIS: A calendar is provided in OTIS to select the date.

5. **Data Sources, References & Citations**: Use local, regional, state, and/or national data to assess the indicator. List the title and year of data sources used in the assessment. In addition to quantitative data, qualitative data sources, such as key informant interviews, focus group findings, and coalition discussions are acceptable data sources.

   OTIS: A drop down menu of common data sources is in OTIS, but you are encouraged to identify additional local data or other references and citations used in your assessment.

6. **Who completed the assessment?** List the coalition name, organization names, or names of the individuals who reviewed, discussed, and rated the indicator.

7. **Record Keeping**: For audit and record keeping purposes it is recommended that you maintain a file with the data documents used to rate each indicator along with a copy of the completed worksheet. Do not submit these documents to CTCP.

Community Readiness - Worksheet B

Purpose: This worksheet is used to assess the community's readiness to work on a policy or system change relevant to the indicator in terms of 1) adopting a change, 2) implementing a change, or 3) facilitating acceptance and compliance with a change.

1. **Community Readiness Measure**: Community Readiness is composed of five items: 1) Scope of the Problem, 2) Community Awareness, 3) Community Support 4) Decision Maker Support and 5) Earned Media. Table 3, *Community Readiness Assessment,* describes the assessment question for each item and the rating scale.

2. **Rating Rubric**: The *Community Readiness Rating Rubric* provides a general description for each item on the Likert scale. Refer to it to help you select the most appropriate rating for each of the five items on the Community Readiness Worksheet.

Table 3. Community Readiness Assessment

Community Readiness Assessment		
Item	**Assessment Question**	**Rating Scale See Rating Rubric**
Scope of the Problem	To what extent do local, regional, state or national data demonstrate the existence of a public health problem?	0-5 None to Excellent
Community Awareness	How much awareness is there among community members that a public health problem exists?	0-5 None to Excellent
Community Support	To what extent have community members demonstrated support for action?	0-5 None to Excellent
Decision Maker Support	To what extent have decision makers and community leaders demonstrated support for action (political will)?	0-5 None to Excellent
Earned Media	To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator?	0-5 None to Excellent

3. **Assessment and Rating Process**: For each indicator, tobacco control project staff and coalition members are to review and discuss quantitative and qualitative data relevant to that indicator. Based on this review and discussion of data, consult the rating rubric and assign a rating for each of the five Community Readiness items.

4. **Community Readiness Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

OTIS: OTIS will automatically calculate the Community Readiness Score once the data are entered and saved

If not using OTIS: To manually calculate the Community Readiness Score use the formula provided on the bottom of Worksheet B, Box B-1.

- Sum the individual ratings.
- Divide the sum by the total possible score (25).
- Multiply the results by 100 and display the score as a percentage.

Example: If the rating for an indicator totaled 15, the score would be 15÷25×100=60%.

5. **Total Indicator Score - Worksheet F**: Transfer information from Worksheet B to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

6. **Complete Narrative - Worksheet G**: See Worksheet G Instructions.

7. **Complete CX Needs Assessment Overview Report - Worksheet I**: Use Worksheet I to manually create a report that summarizes the Community Readiness Score and narrative justification.

Policy/System Status

Purpose: This assessment is used to describe the status of policy and system change efforts. Policy/System Status consists of three measures: 1) Stage of Change; 2) Quality; and 3) Reach.

1. Stage of Change is a measure that describes where a community is at along the continuum of policy/system change.

2. Quality is a measure of the strength—or the extent of public health protection provided by the policy.

3. Reach describes the proportion of the population covered by legislated policies enacted to date.

Policy/System Status Stage of Change - Worksheet C

Purpose: This worksheet is used to describe what stage of policy or system change a community is at in terms of a) adopting a change, b) implementing a change, or c) facilitating acceptance and compliance with a change. This tool assesses voluntary policies, resolutions, legislated policies, and system changes such as the adoption of an Electronic Medical Record (EMR) system that includes a tobacco use assessment, referral and treatment application.

1. **Assessment and Rating Process**: The Stage of Change assessment and rating should be based on your coalition's knowledge and their discussion of quantitative and qualitative data relevant to the indicator in consultation with the definitions in Table 4, *Policy/System Change Stages*. The rating assigned should reflect the highest level of Stage of Change achieved within the community area assessed. See Table 5, *Rating Tips*, for guidance on handling mixed policy situations.

2. **Stage of Change Measure**: The Stage of Change measure consists of six discrete stages along a continuum of change: *1) No Formal Activities, 2) Planning/Advocating, 3) Policy/ System Change Proposed, 4) Policy/System Change Adopted, 5) Policy Implemented and 6) Compliance/ Enforcement.* See Table 4, *Policy/System Change Stages*, for the definition of each stage.

3. **Rating Scale**: Each Stage of Change is assigned a rating of 0 to 5. Select one stage to represent the stage of change for the **entire** community assessed. See Table 4, *Policy/ System Change Stages*, for a definition of each Stage of Change and the corresponding rating for each stage.

Table 4. Policy/System Change Stages

Policy/System Change Stages		
Stages	**Definition**	**Rating Scale**
No Formal Activities	In this stage, general information gathering and fact finding are underway, but no formal activities specific to the indicator have been completed.	0
Planning/ Advocating	In this stage, partnership development, strategy development (e.g., Midwest Academy Strategy Chart completed), specific data collection, and/or the provision of information and education to key opinion leaders are underway.	1
Policy/System Change Proposed	In this stage, a policy or system change has been drafted or proposed; a resolution may have been enacted; education and media activities are underway; and recruitment of partners beyond core supporters is underway.	2
Policy/System Change Adopted	In this stage: A. A voluntary policy or system change has been adopted and may be implemented **OR** B. A legislated policy has been adopted but not yet implemented. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, planning commission).	3
Policy Implemented	In this stage, a legislated policy(s) has been enacted and implementation is underway which may include: provision of training, communication to stakeholders notifying them of the policy and expectations, posting signage, collecting fees, and conducting compliance checks.	4
Compliance/ Enforcement	In this stage, a high degree of compliance has been achieved with a legislated policy(s). Progressive action is taken to address non-compliance.	5

4. **Rating Tips**: See Table 5, *Rating Tips*, for an explanation on how to handle situations where you have a mixture of systems level, resolutions, voluntary policies, and legislated policies.

Table 5. Rating Tips

Rating Tips	
Situation	**How to Rate**
Mixed stages of change	• If the area assessed is comprised of multiple jurisdictions (e.g., cities, tribes) or multiple organizational entities (e.g., hospitals, college campuses) which are at different stages of policy or system change, give yourself "credit" for the highest level of policy or system change achieved within the community area assessed. • For example, if one legislated smoke-free multi-unit housing policy has been adopted and implemented in the county and 10 voluntary smoke-free policies have been adopted, then rate the stage as "Policy Implemented." • On the Indicator Narrative Summary (Worksheet G) you will describe the mix of stages and approximate the number of voluntary and legislated policies adopted within the assessment area.
A resolution has been adopted, but no voluntary or system changes have been adopted	If the strongest policy/system change adopted to-date is one or more resolutions, then the highest rating possible is a two (2) rating.
Voluntary policies or administrative system changes have been adopted	If only voluntary policies or administrative system changes (e.g., adoption of EMR to assess smoking status) then the highest rating possible is a three (3) rating.

5. **Stage of Change Rating**: Circle the rating for the Stage of Change which best fits the community area assessed.

6. **Stage of Change Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Stage of Change Score once the data are entered and saved.

   If not using OTIS: To manually calculate the Change of Stage Score use the formula provided on the bottom of Worksheet C, Box C-1.

   - Divide your Stage of Change rating by 5.
   - Multiple the results by 100.
   - Display the score as a percentage.

Example: If the Stage of Change rating was 3, the score would be 3÷5×100=60%.

7. **Total Indicator Score - Worksheet F**: Transfer information from Worksheet C to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

8. **Complete Narrative - Worksheet G**: See Worksheet G Instructions.

9. **Complete CX Needs Assessment Overview Report - Worksheet I**: Use Worksheet I to manually create a report that summarizes the Change of Stage rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS once data from individual worksheets are entered and saved.

Policy/System Status Policy Quality - Worksheet D

Purpose: Quality is a measure of the strength—or the extent of public health protection provided by the policy. This worksheet is used to record the quality of **legislated policies** adopted against a pre-defined public health standard. A standard has been established for TRL, MUH, Outdoor SHS, and Tobacco Sampling policies adopted by a county board of supervisors or city council.

1. **Assessment and Rating Process**: CTCP collects and rates TRL, MUH, Outdoor SHS, and Tobacco Sampling ordinances adopted by county boards of supervisors and city councils according to a pre-determined standard.

   - For the CX Needs Assessment, CTCP will calculate a composite local health jurisdiction-wide Policy Quality rating for TRL, MUH, Outdoor SHS, and Tobacco Sampling ordinances from information in the Policy Evaluation Tracking System.
   - The composite rating is computed by calculating the quality rating for each ordinance adopted within the local health jurisdiction, summing the individual quality ratings for "like" types of ordinances and then dividing the sum by the total number of jurisdictions in the local health jurisdiction.
   - Agencies will be able to modify the quality rating calculated by CTCP, but must provide an explanation on the Narrative Summary (Worksheet G) if they do so. For example, if one or more strong policies have been enacted that have not yet been rated by CTCP, the agency may raise the rating, but would need to provide an explanation.
   - When no Policy Quality rating is available, the rating given will be zero.

2. **Rating Scale**: The quality scale is composed of a six item continuum, rated on a scale of 0 to 5. See Table 6, *Policy Quality Rating Scale*, for a definition of each item and the corresponding rating.

Table 6. Policy Quality Rating Scale

Policy Quality Rating Scale		
Items	**Definition**	**Rating Scale**
None	No policies relevant to the indicator have been adopted in the community area assessed.	0
Poor	On average, the legislated policies in the community area assessed meet 1% to 20% of the established standard.	1
Fair	On average, the legislated policies in the community area assessed meet 21% to 40% of the established standard.	2
Good	On average, the legislated policies in the community area assessed meet 41% to 60% of the established standard.	3
Very Good	On average, the legislated policies in the community area assessed meet 61% to 80% of the established standard.	4
Excellent	On average, the legislated policies in the community area assessed meet 81% to 100% of the established standard.	5

3. **Policy Quality Rating**: Circle the score for the Policy Quality which best fits the community area assessed.

4. **Policy Quality Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Policy Quality score once the data are entered and saved.

   If not using OTIS: To manually calculate the Policy Quality Score use the formula provided on the bottom of Worksheet D, Box D-1.

   - Divide your Policy Quality rating by 5.
   - Multiple the results by 100.
   - Display the score as a percentage.

   Example: If the Policy Quality rating was 3, the score would be 3÷5×100=60%.

5. **Total Indicator Score - Worksheet F**: Transfer information from Worksheet D to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS once data from individual worksheets are entered and saved.

6. **Complete Narrative - Worksheet G**: See Worksheet G Instructions.

7. **Complete CX Needs Assessment Overview Report - Worksheet I**: Use Worksheet I to manually create a report that summarizes the Policy Quality rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS once data from individual worksheets are entered and saved.

Policy/System Status Policy Reach - Worksheet E

Purpose: This worksheet is used to record the reach of **legislated policies** adopted by describing the proportion of the population within the local health jurisdiction that is protected by a specific policy change.

1. **Assessment and Rating Process**: CTCP will calculate the reach rating for TRL, MUH, Outdoor SHS, and Tobacco Sampling policies adopted by a board of supervisors or city council. The rating is based on information in the Policy Evaluation Tracking System and population data. It is calculated by summing the populations of the jurisdictions where a specific policy has been enacted and dividing that sum by the total population of the community area assessed. Agencies will be able to modify the rating provided by CTCP, but must provide a narrative explanation if they do so. For example, if one or more policies have been enacted after CTCP provided the Policy Reach rating; an agency may raise the rating, but would need to provide an explanation. When no Policy Reach rating is available, the rating given will be zero.

2. **Rating Scale**: The reach scale is composed of a six item continuum, rated on a scale of 0 to 5. See Table 7 *Policy Reach Rating Scale* for a definition of each item and the corresponding rating.

Table 7. Policy Reach Rating Scale

Policy Reach Rating Scale		
Items	**Definition**	**Rating Scale**
None	No legislated policies have been adopted in the community area assessed.	0
Poor	1% to 20% of the population is protected by the policy change(s).	1
Fair	21% to 40% of the population is protected by the policy change(s).	2
Good	41% to 60% of the population is protected by the policy change(s).	3
Very Good	61% to 80% of the population is protected by the policy change(s).	4
Excellent	81% to 100% of the population is protected by the policy change(s).	5

3. **Policy Reach Rating**: Circle the rating for Policy Reach which best fits the community area assessed.

4. **Policy Reach Score**: To facilitate comparisons, the rating from each assessment form is being converted into a "score."

   OTIS: OTIS will automatically calculate the Policy Reach score once the data are entered and saved.

   If not using OTIS: To manually calculate the Policy Reach Score use the formula provided on the bottom of Worksheet E, Box E-1.

- Divide your Policy Reach rating by 5.
- Multiple the results by 100.
- Display the score as a percentage.

Example: If the Policy Reach rating was 3, the score would be 3÷5×100=60%.

5. **Total Indicator Score - Worksheet F**: Transfer information from Worksheet E to Worksheet F (Total Indicator Score) in order to manually calculate the Total Indicator Score.

   OTIS: These calculations will be automatically performed in OTIS, once data from individual worksheets are entered and saved.

6. **Complete Narrative - Worksheet G**: See Worksheet G Instructions.

7. **CX Needs Assessment Overview Report - Worksheet I**: Use Worksheet I to manually create a report that summarizes the Policy Reach rating, score, and narrative justification.

   OTIS: This report will be created automatically in OTIS, once data from individual worksheets are entered and saved.

Total Indicator Score Calculation Instructions - Worksheet F

Purpose: The purpose of the Total Indicator Score Worksheet is to help you manually calculate preliminary indicator scores prior to entering assessment findings into OTIS. The Total Indicator Score is based on the rating of Community Readiness and Policy Status (Stage of Change + Quality + Reach). Once data is submitted and saved into OTIS, this data will be calculated for you.

Instructions: Prior to entering your ratings into OTIS, it is likely that you will want to calculate the Total Indicator Score manually in order to give your coalition instant feedback.

1. Record the indicator number and brief title.

2. Record the Community Readiness Rating and Score from Box B-1 of the Community Readiness: Worksheet B.

3. Record the Stage of Change Rating from Box C-1 of the Stage of Change: Worksheet C.

4. Record the Quality Rating from Box D-1 of the Policy Quality: Worksheet D.

5. Record the Reach Rating from Box E-1 of the Policy Reach: Worksheet E.

6. Add lines 2a, 2b, and 2c and record the number. Divide that number by 15. This is your **Total Policy/System Status Score**.

7. Add the lines 1 and 3 and record the number. Divide that number by 40. This is your **Total Indicator Score**.

Indicator Narrative Summary Instructions - Worksheet G

Purpose: The purpose of the narrative is to summarize quantitative and qualitative information which explains and supports the Community Readiness and Policy/System Status scores.

Instructions: In a narrative format provide a descriptive summary response to each of the questions listed on Worksheet G.

1. **Community Readiness Status – Scope of the Problem and Support**: Summarize key quantitative and qualitative data from the discussion about the Scope of the Problem, Community Awareness, and Community/Decision Maker Support. (limited to 300 words.) Include the following information in the summary:

    - Awareness of the problem and support/opposition for addressing this indicator.
    - Highlight any subpopulations or geographical communities for which there are special needs related to community readiness for policy/system change.

2. **Community Readiness Status – Outreach**: Summarize and record the history of intervention activities related to the indicator. (limited to 300 words.) Include the following information in the summary:

    - Partnership development activities
    - Educational outreach to community decision makers
    - Media activities
    - Policy and system change activities
    - Enforcement and compliance activities

3. **Voluntary Policy Status**: Estimate the approximate number of voluntary policies or resolutions that have been adopted related to the indicator or check "Don't Know." (limited to 100 words.)

4. **Legislated Policy Status**: Estimate the approximate number of legislated policies that have been adopted which are relevant to the indicator. (limited to 100 words.)

5. **Modification of Policy Quality or Reach Scores**: If the Policy Quality or Policy Reach scores were modified from that provided by CTCP, provide an explanation that supports the change. (limited to 300 words.)

Indicator Assessment Cover Page

Indicator #:	Indicator Title:

Core Indicator? (Circle one) Yes No

Community Area(s) Assessed:

Indicator Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Indicator rating? (Title and Year)

Who was engaged in discussing and completing the Indicator rating? (List the coalition name, organizational names, or names of individuals.)

Community Readiness - Worksheet B

Instructions: What is the community's readiness for working on policy/system change adoption, implementation, or compliance and enforcement relevant to this indicator? Check a single box for each item.

	None (0)	Poor (1)	Fair (2)	Good (3)	Very Good (4)	Excellent (5)
1. **Scope of the Problem.** To what extent do local, regional, state, or national data demonstrate the existence of a public health problem?	☐	☐	☐	☐	☐	☐
2. **Community Awareness.** How much awareness is there among community members that a public health problem exists?	☐	☐	☐	☐	☐	☐
3. **Community Support.** To what extent have community members demonstrated support for action?	☐	☐	☐	☐	☐	☐
4. **Decision Maker Support.** To what extent have decision makers and community leaders demonstrated support for action (political will)?	☐	☐	☐	☐	☐	☐
5. **Earned Media.** To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator?	☐	☐	☐	☐	☐	☐

Box B-1

Community Readiness Score: Add lines 1 through 5 ☐ x $\frac{100}{25}$ = ☐ %

Policy/System Status Stage of Change - Worksheet C

Instructions: For this indicator, what is the overall stage of policy adoption or system change in the community area assessed? Circle the most applicable rating.

Policy/System Change Stage. Refers to the policy adoption stage of the assessed area.	**Rating**
No Formal Activities. In this stage, general information gathering and fact finding are underway, but no formal activities specific to the indicator have been completed.	0
Planning/Advocating. In this stage, partnership development, strategy development (e.g., Midwest Academy Strategy Chart completed), specific data collection, and/or the provision of information and education to key opinion leaders are underway.	1
Policy/System Change Proposed. In this stage, a policy or system change has been drafted or proposed; a resolution may have been enacted; education and media activities are underway; and recruitment of partners beyond core supporters is underway.	2
Policy/System Change Adopted. In this stage: A. A voluntary policy or system change has been adopted and may be implemented **OR** B. A legislated policy has been adopted but not yet implemented. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, or planning commission).	3
Policy Implemented. In this stage, a ***legislated policy(s)*** has been enacted and implementation is underway which may include: provision of training, communication to stakeholders notifying them of the policy and expectations, posting signage, collecting fees, and conducting compliance checks.	4
Compliance/Enforcement. In this stage, a high degree of compliance has been achieved with a ***legislated policy(s)***. Progressive action is taken to address non-compliance.	5

Box C-1

Policy/System Change Stage Score: Insert rating from above [ ] x $\frac{100}{5}$ = [ ] %

Policy/System Status Policy Quality - Worksheet D

Instructions: For this indicator, what is the overall quality of the policies adopted in the community area assessed? CTCP will provide an established standard using the Policy Evaluation Tracking System. Circle the most applicable rating.

Quality Rating: Refers to how well the requirements in a legislated policy meet an established standard.	**Rating**
None. No policies relevant to the indicator have been adopted in the community area assessed.	0
Poor. On average, the legislated policies in the community area assessed meet 1% to 20% of the established standard. A ***legislated policy*** is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, planning commission).	1
Fair. On average, the legislated policies in the community area assessed meet 21% to 40% of the established standard.	2
Good. On average, the legislated policies in the community area assessed meet 41% to 60% of the established standard.	3
Very Good. On average, the legislated policies in the community area assessed meet 61% to 80% of the established standard.	4
Excellent. On average, the legislated policies in the community area assessed meet 81% to 100% of the established standard.	5

Box D-1

Policy Quality Score: Insert rating from above [ ] x $\frac{100}{5}$ = [ ] %

Policy/System Status Policy Reach - Worksheet E

Instructions: For this indicator, what is the overall population reach of the policies adopted in the community area assessed? Circle the most applicable rating.

Reach. Refers to the percentage of the population in the area assessed (e.g. county, city) that is covered by a legislated county or city policy.	**Rating**
None. No legislated policies have been adopted in the community area assessed.	0
Poor. 1% to 20% of the population is protected by the policy change(s).	1
Fair. 21% to 40% of the population is protected by the policy change(s).	2
Good. 41% to 60% of the population is protected by the policy change(s).	3
Very Good. 61% to 80% of the population is protected by the policy change(s).	4
Excellent. 81% to 100% of the population is protected by the policy change(s).	5

Box E-1

Policy Reach Score:	Insert rating from above		x $\frac{100}{5}$ =		%

Total Indicator Score - Worksheet F

Instructions: OTIS will calculate a Total Score for each indicator based on your Community Readiness and Policy Status. The OTIS Communities of Excellence in Tobacco Control Overview Report (OTIS CX Overview Report) will compile the Total Score, sub scores, and narrative comments for each indicator.

To manually calculate the total score for an indicator, use this form:

Indicator #	Indicator Title:	Rating	Score
		#	%
Community Readiness	**1. Transfer the rating sum and score from Worksheet B, Box B-1**	_____	_____
Policy System Status	**2a. Stage of Change** Transfer the rating and score fro Worksheet C, Box C-1	_____	_____
	2b. Policy Quality Transfer the rating and score from Worksheet D, Box D-1	_____	_____
	2c. Policy Reach Transfer the rating and score from Worksheet E, Box E-1	_____	_____
	3. Total Policy/System Status Add lines 2a+2b+2c. Record that number. Divide the sum of (2a+2b+2c) by 15 to get the percentage	**(2a+2b+2c)=** _____**Total**	**(Line 3 Total) ÷ 15** _____
Total Indicator Score	**4. Total Indicator Score** Add lines 1 and 3. Record that number. Divide the sum of lines (1 + 3) by 40 to get the percentage.	**(1 + 3)=** _____**Total**	**(Line 4 Total) ÷ 40** ☐

Indicator Narrative Summary - Worksheet G

Purpose: The purpose of the narrative is to provide information which explains and supports the Community Readiness and Policy/System Status scores.

Instructions: In a narrative format provide a descriptive summary which includes the following information:

1. Summarize key data and findings related to the status of the indicator, including awareness of the problem and support/opposition for addressing this indicator. Highlight any subpopulations or geographical communities for which there are special needs related to community readiness for policy/system change related to the indicator. (limited to 300 words.)

2. Summarize partnership development activities, educational outreach to community decision makers, media activities, policy/system change implementation activities, enforcement activities, or compliance activities conducted by your agency or other agencies in the local health jurisdiction related to the indicator. (limited to 300 words.)

3. Estimate the approximate number of voluntary policies or resolutions that have been adopted related to the indicator or check "Don't Know." (limited to 100 words.)

   ☐ Don't Know

4. Estimate the approximate number of legislated policies related to the indicator that have been adopted. (limited to 100 words.)

5. If the Policy Quality or Policy Reach scores were modified from that provided by CTCP, provide an explanation that supports the change. (limited to 300 words.)

Community Readiness Rating Rubric

Worksheet B

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.	**Scope of the Problem:** To what extent do local, regional, state or national data demonstrate the existence of a public health problem relevant to this indicator?	**No** national, state, regional, or local data exists relevant to the indicator.	**National, state, regional, or local** data relevant to the indicator are available. Data are **more than 5** years old.	**Only state OR national** data relevant to the indicator are available. Data were collected **within the last 5** years.	**State AND regional** data relevant to the indicator are available. Data were collected **within the last 5** years. Together these data describe who is impacted by the problem and the health or social impact of the problem.	**Local** data relevant to the indicator are available. Data were collected **within the last 3** years. The local data describe who is impacted by the problem, the health or social impact of the problem, and **community awareness about the problem.**	**Robust local** data relevant to the indicator are available. Data were collected **within the last 3** years. The data describe who is impacted by the problem, the health or social impact of the problem, community awareness about the problem, **community support for addressing the problem, and decision-maker support for addressing the problem.**

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.	**Community Awareness:** How much awareness is there among community members that a public health problem exists relevant to this indicator?	The community is generally **not** aware that a problem exists.	There is **vague** awareness that a problem exists.	There is **general** awareness that a problem may exist, but it is not perceived as a local problem.	There is **clear** awareness that a **local** problem exists; **50% or less** of the population is aware of the problem. Awareness **may be lower in many** geographic areas or among specific racial/cultural groups.	There is **high** awareness that a **local** problem exists; **Greater than 50% but less than 75%** of the population is aware of the problem. Awareness **may be lower in a few** geographic areas or among specific racial/cultural groups.	There is **extremely high** awareness that a **local** problem exists; **75% or more** of the population is aware of the problem. Awareness is **generally good across all** geographic areas and racial/cultural groups.

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.	**Community Support:** To what extent have community members demonstrated support for action relevant to this indicator?	There is **no** community support for action relevant to the issue. In fact, **strong opposition** may have been expressed.	In general, the community is **indifferent** to the issue.	There is **passive** support for the issue. In general, **few** community members or organizations have **considered** taking action such as forming a committee, collecting local data, conducting awareness raising and education programs, or seeking funding.	There is **active** community support for the issue. Planning and preparation activities have been **initiated** such as forming a committee, collecting local data, conducting awareness raising and education programs, strategic planning, or applying for funding to address the issue. State or local attitudes, belief, opinion polls, and intercept surveys demonstrate that **50% or less** of the population supports various intervention strategies to support the issue.	**Active** community support for the issue has moved from planning and preparation activities among core supporters to **engaging** additional people through conducting educational and media outreach. State or local attitudes, belief, opinion polls, and intercept surveys demonstrate that **greater than 50% but less than 75%** of the population supports various intervention strategies to support the issue.	Informal and formal community leaders have demonstrated their support by **offering** tangible assistance with policy or system change or compliance/ enforcement efforts. State or local attitudes, belief, opinion polls, and intercept surveys demonstrate that 7**5% or more** of the population supports various intervention strategies to support the issue.

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
4.	**Decision Maker Support:** To what extent have decision makers and community leaders demonstrated support for action (political will) relevant to this indicator?	There is **no** decision maker support for action relevant to the issue. In fact, **strong opposition** may have been expressed.	In general, the decision makers are **indifferent** to the issue.	There is **passive support** for the issue among decision makers. Decision makers have not been motivated to take any action beyond fact finding to address the problem.	There is **active support** for the issue expressed by **one or more** influential decision makers. **Exploration** of various solutions is **underway**.	**One or more** decision makers have publicly identified themselves as a **champion** for the issue.	A **majority** of decision makers who have the authority to take action on a policy or system change or compliance/ enforcement effort have **publically voiced support** for specific action relevant to the issue.

	Community Readiness Question	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
5.	**Earned Media:** To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator? The focus of this assessment is on the amount of earned media related to the indicator, rather than on who generated the earned media. The earned media may have been generated as a result of local, regional, state, or national efforts. Earned media refers to unpaid publicity and press coverage through either mainstream outlets like television, radio, print, talk shows, editorials, or letters to the editor, traditional web publishers, or social media outlets like blogs, community forums, and podcasts. Earned media does <u>not</u> include paid marketing such as advertising and sponsorships.	In the past three years, **no** earned media items relevant to the indicator have appeared in the community from local, regional, state, or national sources.	**At least 1 unpaid earned media item per year** relevant to the indicator has appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 2 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 3 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 4 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years.	**At least 5 unpaid earned media items per year** relevant to the indicator have appeared in the community from local, regional, state, or national sources, in the past three years. Additionally, earned media is **routinely used to increase** awareness about this issue and to set an agenda.

Asset Assessment Instructions

Purpose: The Asset Worksheet findings will be used to help identify factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. You will be able to determine "how much" or "to what extent" an issue is being addressed in your community.

Assessment and Rating Process: The assessment and rating of Assets should be based on your coalition's knowledge of the assets and a discussion of all relevant quantitative and qualitative data collected and reviewed. Refer to the Assets Rating Rubric to help guide the discussion. In addition to rating the assets, you will write a brief narrative summary (limited to 500 words) which explains and supports the rating given to each asset.

Cover Page

1. **Asset Numbers and Titles:** List the number and brief title for each asset rated.

   OTIS: A drop down menu is provided in the Online Tobacco Information System (OTIS).

2. **Core Asset:** A "core" asset is one that every agency must assess. Refer to the funding guidelines/procurement for a list of the core assets. List the number for each core asset rated.

   OTIS: In OTIS, this field will be pre-populated.

3. **Community Area(s) Assessed:** Identify the community name(s) that best reflects the geographical area assessed. In general, county health departments should use a countywide perspective and city health departments should use a citywide perspective. However, there may be times when it is appropriate to use a different frame of reference for the assessment.

   OTIS: In OTIS there are drop down menus for four types of communities: 1) countywide, 2) incorporated cities, 3) unincorporated communities, and 4) Indian tribal lands.

4. **Completion Date:** Identify the month, day, and year your agency completed the Asset Assessment.

   OTIS: A calendar is provided in OTIS to select the date.

5. **Data Sources, References & Citations:** Use local, regional, state and/or national data to assess the assets. List the title and year of data sources used in the assessment. Qualitative data sources, such as key informant interviews, focus group findings, and coalition discussions are acceptable data sources.

   OTIS: A drop down menu of common data sources is in OTIS, but you are encouraged to

identify additional local data or other references and citations.

6. **Who completed the assessment?** List the coalition name, organization names, or the names of individuals who reviewed data and rated the assets.

7. **Record Keeping:** For audit and record keeping purposes it is recommended that you maintain a file with the data documents used to rate each asset along with a copy of the completed worksheet. Do not submit these documents to CTCP.

Asset Rating - Worksheet H

1. **Rating Scale:** Each asset is rated on a six point (0 to 5) Likert scale of *None, Poor, Fair, Good, Very Good, and Excellent*. You are not required to rate every asset. A "Not Rated" (NR) response is provided for those assets you do not rate.

   OTIS: In OTIS, a drop down menu is provided.

2. **Rating Rubric:** Refer to the *Asset Rating Rubric* to help you with the assessment. The rubric provides a general definition or meaning for each measure on the Likert scale and will help guide your rating of each asset.

3. **Core Assets:** You are required to complete any Asset which is identified as a "Core" Asset in the funding document (e.g., Local Lead Agency Guidelines, Request for Application, Request for Proposal).

   OTIS: In OTIS, this field will be pre-populated.

4. **Non-Core Assets:** Completion of non-core assets is optional. However, in order to include an objective and activities related to a specific asset, you must have assessed the asset.

5. **Rating Assets:** Assign a rating of None to Excellent for each asset rated. For assets that are not rated, circle "NR" for not rated.

6. **Comments:** A "Comments" field is provided following each asset. Completion of this field is mandatory. (limited to 500 words.) Use this field to record information that justifies and supports the rating. It is important that your comments substantiate and/or explain the rating given in order to provide context and background to the reviewers of your funding application.

7. **Complete CX Needs Assessment Overview Report Worksheet I:** Transfer the individual assets ratings to Worksheet I to manually create a report that summarizes your assessment conclusions.

   OTIS: This report will be created automatically in OTIS once data from the Asset Rating Worksheet is entered and saved in OTIS.

Asset Assessment Cover Page

Asset #:	Asset Title(s):

Which were Core Assets? (Provide Asset Numbers)

Community Area(s) Assessed:

Asset Assessment Completion Date:

Which quantitative and qualitative data sources, references, and citations were used to complete the Asset ratings? (Title and Year)

Who was engaged in discussing and completing the Asset ratings? (List the coalition name, organizational names or the names of individuals.)

Asset Rating - Worksheet H

Instructions: Based on your review and discussion of data, circle the most appropriate rating. Circle "NR" (not rated) for those assets which you are not rating.

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
1.1	**Tobacco Control Funding:** Global per capita appropriation for tobacco control activities, from various sources, is consistent with the recommendations of the National Association of County and City Health Officials: • <100,000 population:$8-$10/ capita; • 100,001-500,000 population: $6-$8/ capita; • >500,000 population: $4-$6/capita. Subset of Global per capita funding for school programs: • $4-$6 per student regardless of student population size.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
1.2	**Master Settlement Agreement (MSA) Funding:** The amount of MSA funds that are appropriated for the purpose of tobacco control activities.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
1.3	**Proposition 10 Funding:** The amount of local Proposition 10 funds that are appropriated for cessation and secondhand smoke education targeting pregnant women and families with young children.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
1.4	**Affordable Care Act Community Health Needs Assessment Participation:** The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act* for the purpose of promoting the inclusion of indicators and interventions that support tobacco-free living (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement and advocacy, workforce development, other community development activities to build health and safety). *SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
2.1	**Training and Skill Building:** The extent training and technical assistance are available to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
2.2	**Coalition/Advisory Committee Satisfaction:** The extent of satisfaction among coalition or advisory committee members with program planning, involvement of the community, implementation activities, quality of services, and progress made by the project.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
2.3	**Key Opinion Leader Support:** The extent of support among local key opinion leaders for tobacco-related community norm change strategies.							
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
2.4	**Youth Engagement in Tobacco Control:** The extent our tobacco control program has participatory collaborative partnerships with diverse youth and youth serving organizations and mobilizes their involvement in community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
2.5	**Adult Engagement in Tobacco Control:** The extent our tobacco control program has participatory collaborative partnerships with diverse adults and non-Proposition 99 funded adult serving organizations and mobilizes their involvement in community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
3.1	**Coalition/Advisory Committee Diversity:** The extent our tobacco control program has built and engages a diverse coalition or advisory committee in designing and implementing tobacco control activities. Diversity is inclusive of ethnicity, culture, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
3.3	**Cultural Competence Assessment:** The extent our tobacco control program periodically conducts self-assessments of organizational cultural competence.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

	Community Asset	None	Poor	Fair	Good	Very Good	Excellent	
3.4	**Tailored Educational and Outreach Materials:** The extent our tobacco control program makes culturally appropriate educational, outreach and media materials easily available and appropriate for the languages and literacy levels of commonly encountered groups in the service area.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							
3.6	**Equity in Funding:** The extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.	**0**	**1**	**2**	**3**	**4**	**5**	**NR**
	Comments:							

Assets Rating Rubric

Worksheet H

Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.1 **Tobacco Control Funding:** Global per capita appropriation for tobacco control activities, from various sources, is consistent with the recommendations of the National Association of County and City Health Officials: • <100,000 population: $8-$10/capita; • 100,001-500,000 population: $6-$8/capita; • >500,001 population: $4-$6/capita. Subset of Global per capita funding for school projects: • $4-$6 per student regardless of student population size.	**No** local funding, including Proposition 99, is appropriated for tobacco control.	Per capita appropriation for tobacco control in the community area assessed from all sources such as Proposition 99- Local Lead Agencies, Proposition 99- Competitive Grant awards, Proposition 10, Master Settlement Agreement (MSA), federal funds (e.g. Community Transformation Grants (CTG), foundation funds, local funds) is:	Per capita appropriation for tobacco control in the community area assessed from all sources such as Proposition 99- Local Lead Agencies, Proposition 99- Competitive Grant awards, Proposition 10, MSA, federal funds (e.g. CTG, foundation funds, local funds) is:	Per capita appropriation for tobacco control in the community area assessed from all sources such as Proposition 99- Local Lead Agencies, Proposition 99- Competitive Grant awards, Proposition 10, MSA, federal funds (e.g. CTG, foundation funds, local funds) is:	Per capita appropriation for tobacco control in the community area assessed from all sources such as Proposition 99- Local Lead Agencies, Proposition 99- Competitive Grant awards, Proposition 10, MSA, federal funds (e.g. CTG, foundation funds, local funds) is:	Per capita appropriation for tobacco control in the community area assessed from all sources such as Proposition 99- Local Lead Agencies, Proposition 99- Competitive Grant awards, Proposition 10, MSA, federal funds (e.g. CTG, foundation funds, local funds) is:

Continued on the next page

1.1	**Tobacco Control Funding:** *Continued*	Population <100,000: **Less than $4** per capita in the community area assessed. Population 100,001-500,000: **Less than $3** per capita in the community area assessed. Population >500,000: **Less than $2** per capita in the community area assessed. School Funding-All Communities: **Less than $2** per student	Population <100,000: **At least $4** per capita in the community area assessed. Population 100,001-500,000: **At least $3** per capita in the community area assessed. Population >500,000: **At least $2** per capita in the community area assessed. School Funding-All Communities: **At least $2** per student.	Population <100,000: **About $8** per capita in the community area assessed. Population 100,001-500,000: **About $6** per capita in the community area assessed. Population >500,000: **About $4** per capita in the community area assessed. School Funding-All Communities: **About $4** per student.	Population <100,000: **About $9** per capita in the community area assessed. Population 100,001-500,000: **About $7** per capita in the community area assessed. Population >500,000: **About $5** per capita in the community area assessed. School Funding-All Communities: **About $5** per student.	Population <100,000: **About $10 Or More** per capita in the community area assessed. Population 100,001-500,000: **About $8** or more per capita in the community area assessed. Population >500,000: **About $6** or more per capita in the community area assessed. School Funding-All Communities: **About $6** per student.

Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.2 **Master Settlement Agreement (MSA) Funding:** The amount of MSA funds that are appropriated for the purpose of tobacco control activities.	**No** city or county MSA funds are appropriated for the purpose of tobacco control activities.	Annual MSA appropriation is **>0% but ≤ 25%** of the health department's annual Proposition 99 Local Lead Agency (LLA) allocation.	Annual MSA appropria-tion is **>25%, but ≤ 50%** of the health department's annual Proposition 99 LLA allocation.	Annual MSA appropriation is **>50%, but ≤75%** of the health department's annual Proposition 99 LLA allocation.	Annual MSA appropria-tion is **>75%, but ≤ 100%** of the health depart-ment's annual Proposition 99 LLA allocation.	Annual MSA appropriation is **greater** than the health department's annual Proposition 99 LLA allocation.

Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.3 **Proposition 10 funding:** The amount of local Proposition 10 funds that are appropriated for cessation and second-hand smoke education targeting pregnant women and families with young children.	The local Proposition 10 Commission Plan **does not** address cessation and secondhand smoke education targeting pregnant women and families with young children.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children, -but- **no** specific projects or activities are identified.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -but- **less than 1%** of the health jurisdiction's Proposition 10 allocation is for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- appropriates **1%** of the health jurisdiction's Proposition 10 allocation for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- appropriates **greater than 1% and less than 5%** of the health jurisdiction's Proposition 10 allocation for these activities.	The local Proposition 10 Commission Plan **includes** goals and objectives addressing cessation and secondhand smoke education targeting pregnant women and families with young children -and- appropriates **5% or more** of the health jurisdiction's Proposition 10 allocation for these activities.

	Tobacco Control Funding Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
1.4	**Affordable Care Act Community Health Needs Assessment Participation**: The number of local tobacco control advocates who actively participate in the Community Health Needs Assessment (CHNA) which is required to be conducted by non-profit hospitals every three years pursuant to the Affordable Care Act* for the purpose of promoting the inclusion of indicators and interventions that support *tobacco-free living*** (e.g., physical environment and housing improvements, economic development, community support, leadership development, coalition development, community health improvement and advocacy, workforce development, other community development activities to build health and safety). *[SEC. 9097: Additional Requirements for Charitable Hospitals and as defined in Internal Revenue Service, Schedule H instructions (Form 990), 2011].	Tobacco control advocates have **not** approached local hospitals about participating in the CHNA -and- **none** participated in the development of the most recent CHNA.	Tobacco control advocates approached local hospitals about participating in the CHNA, -but- **none** were active participants in the most recent CHNA.	**At least 1** tobacco control advocate participated in the most recent CHNA, -but- the needs assessment plan **did not** address interventions that support *tobacco free living***	**At least 1** tobacco control advocate participated in the most recent CHNA -and- the plan **explic-itly addressed** interventions that support *tobacco free living***	**More than 1** tobacco control advocate actively participated in the most recent CHNA –and- the resulting plan includes **at least 1** explicit tobacco control indicator -and- **at least 2** measures that support *tobacco free living***	Tobacco control advocates actively participated in the most recent CHNA -and- the resulting plan includes **more than 1** explicit tobacco control indicator –and- **at least 3** measures that support *tobacco free living***

	Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.1	**Training and Skill Building**: The extent training and technical assistance are available to diverse community groups to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**No** tobacco control training and skill building activities were provided by our project to diverse commu-nity groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**One** tobacco control advocacy training or skill building activity was provided to diverse commu-nity groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Two** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Three** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Four** tobacco control advocacy training or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.	**Five or more** tobacco control advocacy or skill building activities were provided to diverse community groups in the **past 12 months** to enable them to effectively engage in tobacco control activities and activities to reduce tobacco-related social determinants of health.

Social Capital Assets		None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.2	**Coalition/ Advisory Committee Satisfaction:** The extent of satisfaction among coalition or advisory committee members with: program planning, involvement of the community, implementation activities, quality of services, and progress made by the project.	**No** satisfaction survey was disseminated in the last 18 months to assess satisfaction with program planning, involvement of the community, implementation activities, quality of services, or progress made.	A satisfaction survey was disseminated in the last 18 months. **No to very low** satisfaction was expressed by members on **3 or more** of the following measures: program planning, involvement of the community, implementation of activities, quality of services, or progress made.	A satisfaction survey was disseminated in the last 18 months. Members expressed **fairly low satisfaction** on **2** of the following measures, but **others were rated somewhat satisfied to very satisfied:** program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 18 months. Members were **somewhat satisfied** with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 18 months. Members expressed **satisfaction** with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.	A satisfaction survey was disseminated in the last 18 months. Members expressed **high to very high** satisfaction with regard to: program planning, involvement of the community, implementation of activities, quality of services, and progress made.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.3 **Key Opinion Leader Support**: The extent of support among local key opinion leaders for tobacco-related community norm change strategies.	There is **no** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Statements are made by policy makers to not accept Proposition 99 funding. There's **opposition** to applying for federal tobacco control funding.	There is **minimal** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Support is generally tied to youth-only initiatives. There's **little** support to apply for federal tobacco control funding.	There is **some** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Support is generally tied to youth-only initiatives. There's **mixed** support to apply for federal tobacco control funding.	There is **consistent** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. There is support for initiatives that go beyond youth focus. There's **strong** support to apply for federal tobacco control funding.	There is **consistent** and **progressive** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Local key opinion leaders initiate community norm change strategies. There's **very strong** support to apply for federal tobacco control funding.	There is **consistent** and **progressive** support for tobacco-related community norm change strategies among local key opinion leaders as evidenced by surveys, key informant interviews, policy votes, statements in the media, etc. Local key opinion leaders initiate community norm change strategies. There's **demonstrated leadership and very strong** support to apply for federal tobacco control funding.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.4 **Youth Engagement in Tobacco Control**: The extent our tobacco control program has participatory collaborative partnerships with diverse youth and youth serving organizations and mobilizes their involvement in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.	Our tobacco control program **never** has diverse youth and youth serving agencies participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.	**At least 1 time per year**, our tobacco control program has diverse youth and youth serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.	**At least 2 times per year**, our tobacco control program has diverse youth and youth serving organizations occasionally participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.	**At least 3 times per year**, our tobacco control program has diverse youth and youth serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.	**At least 4 times per year**, our tobacco control program has diverse youth and youth serving agencies participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.	**At least 5 times per year**, our tobacco control program involves diverse youth and youth serving agencies who initiate, organize and participate in and organize: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental and system change; and activities that address tobacco-related social determinants of health.

Social Capital Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
2.5 **Adult Engagement in Tobacco Control**: The extent our tobacco control program has participatory collaborative partnerships with diverse adults and non-Proposition 99 funded adult serving organizations and mobilizes their involvement in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and engages them in activities that address tobacco-related determinants of health.	Our tobacco control program **never** has diverse non-paid Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.	**At least 1 time per year**, our tobacco control program has diverse non-paid Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.	**At least 2 times per year**, our tobacco control program has diverse non-Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.	**At least 3 times per year**, our tobacco control program has diverse non-Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.	**At least 4 times per year**, our tobacco control program, has diverse non-Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.	**At least 5 times per year**, our tobacco control program has diverse non-Proposition 99 funded adults and adult serving organizations participate in: community assessments; development, implementation, and evaluation of interventions to support tobacco control-related policy, environmental, and system change; and activities that address tobacco-related social determinants of health.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.1 **Coalition/ Advisory Committee Diversity**: The extent our tobacco control program has built and engages a diverse coalition or advisory committee in designing and implementing tobacco control activities. Diversity is inclusive of ethnicity, culture, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).	Our tobacco control program has **not built and engaged** a diverse coalition or advisory committee in designing and implementing tobacco control activities.	Our tobacco control program **has built and engaged** a coalition or advisory committee in which **a few** of the groups from our demographic profile are represented among the membership and the executive leadership of the group. Members are **rarely involved** in designing and implementing tobacco control activities.	Our tobacco control program has **built and engaged** a coalition or advisory committee in which **some** of the groups from our demographic profile are represented among the membership and are engaged in the executive leadership of the group. Members are **sometimes involved** in designing and implementing tobacco control activities.	Our tobacco control program has **built and engaged** a diverse coalition or advisory committee in which **most** of the racial/ ethnic groups from our demographic profile are represented among the membership and are engaged in the executive leadership of the group. Members are **usually involved** in designing and implementing tobacco control activities.	Our tobacco control program has **built and engaged** a diverse coalition or advisory committee in which **all** racial/ethnic groups from our demographic profile are represented among the membership and are engaged in the executive leadership of the group. Members are almost **always involved** in designing and implementing tobacco control activities.	Our tobacco control program has **built and engaged** a highly diverse coalition or advisory committee in which **all** racial/ethnic groups from our demographic profile are represented among the membership and engaged in the executive leadership of the group. Members are **always highly** involved in designing and implementing tobacco control activities.

	Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.3	**Cultural Competence Assessment**: The extent our tobacco control program periodically conducts self-assessments of organizational cultural competence.	Our tobacco control program has **no current** plans to perform a self-assessment of cultural competence.	Our tobacco control program has **discussed or planned** self-assessments of cultural competence -but- has **not completed** one.	Our tobacco control program **performed** self-assessments of cultural competence in the past -but- has **not done so in more than 3 years.**	Our tobacco control program has **performed** self-assessments of cultural competence within the past three years -but- has done so on an **ad hoc basis or inconsistently over time.**	Our tobacco control program **follows** the NMCI cultural competency model -but- has **not used the results** to make project improvements.	Our tobacco control program **follows** the NMCI cultural competency model -and- **uses the results** to make project improvements.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.4 **Tailored Educational and Outreach Materials**: The extent our tobacco control program makes culturally appropriate educational, outreach and media materials easily available and appropriate for the languages and literacy levels of commonly encountered groups in the service area.	Educational and media materials used by our tobacco control program **do not reflect** the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community.	Educational and media materials used by our tobacco control program **currently do not reflect** the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community. However, there are materials that are **being developed and/or being revised** to work toward meeting this gap.	Educational and media materials used by our tobacco control program **reflect a few** of the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community, -but- there are **major gaps** in terms of the populations and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect several** of the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community, -but- there are **some gaps** in terms of the populations and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect most** of the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community, -but- there are **a few gaps** in terms of the populations and/or breadth of subject matter.	Educational and media materials used by our tobacco control program **reflect all** of the major cultural, ethnic, or language needs of the communities served, relative to the demographics of the community. There are **no gaps** in terms of the populations and/or breadth of subject matter.

Cultural Diversity and Cultural Competence Assets	None 0	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
3.6 **Equity in Funding**: The extent to which culturally and ethnically diverse organizations are funded to implement community norm change-focused tobacco control efforts in the community, in proportion to community demographics.	**No** culturally and ethnically diverse organizations are funded to implement community norm focused tobacco control efforts in the community.	**No** culturally and ethnically diverse organizations are funded to implement community norm focused tobacco control efforts in the community. However, **at least one** mainstream organization such as the local health department or voluntary health organization is funding a specific community norm focused tobacco control effort within a culturally or ethnically diverse community.	**One** culturally or ethnically diverse organization, in proportion to the demographics of the community, is funded to implement community norm focused tobacco control efforts.	**Two or three** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm focused tobacco control efforts.	**Four or five** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm focused tobacco control efforts.	**More than five** culturally or ethnically diverse organizations, in proportion to the demographics of the community, are funded to implement community norm focused tobacco control efforts.

Needs Assessment Overview Report Instructions

Purpose: The purpose of the Needs Assessment Overview Report Worksheet I is to display and organize on one worksheet all of the scores and narratives for your CX needs assessment, prior to viewing this information in OTIS. This report will be created automatically in OTIS, once data from individual worksheets are entered and saved.

Instructions: Once individual worksheet data are entered and saved in OTIS, this information will be used to populate the Needs Assessment Overview Report. However, if you want to give your coalition instant feedback, you will need to transfer the information from the individual worksheets onto the Needs Assessment Overview Report Worksheet.

1. **Cover Page Information**

   Write down your agency name, community area(s) assessed, and date the CX assessment was completed.

2. **Record the Social Disparities Score**

   - Transfer the ratings from the Social Disparities Capacity Rating - Worksheet A (Items 1 through 5) to page 1 of Worksheet I. (page 97)

   - Transfer the score from Box A-1 of the Social Disparities Capacity Rating - Worksheet A to page 1 of Worksheet I. (page 97)

   - Record important facts from the Social Disparities Capacity Narrative Summary on page 1 of Worksheet I. (page 97)

3. **Record the Indicator Ratings and Score**

   - Record the indicator number and brief title on page 2 of Worksheet I, column 1. (page 98)

   - Transfer the score from Box B-1 of the Community Readiness - Worksheet B to page 2 of Worksheet I, column 2. (page 98)

   - Transfer the score from Box C-1 of the Stage of Change - Worksheet C to page 2 of Worksheet I, column 3. (page 98)

   - Transfer the score from Box D-1 of the Policy Quality - Worksheet D to page 2 of Worksheet I, column 4. (page 98)

- Transfer the score from Box E-1 of the Policy Reach - Worksheet E to page 2 of Worksheet I, column 5. (page 98)

- Transfer the score from Line 3 of the Total Indicator Score - Worksheet F to page 2 of Worksheet I, column 6. (page 98)

- Transfer the score from Line 4 of the Total Indicator Score - Worksheet F to page 2 of Worksheet I, column 7. (page 98)

- Transfer important facts from the Narrative Summary - Worksheet G to page 2 of Worksheet I, column 8. (page 98)

4. Record the Asset Score

- Record the asset number and brief title on page 3 of Worksheet I, column 1. (page 99)

- Transfer the rating circled for each of the assets rated in the Asset Rating - Worksheet H to page 3 of Worksheet I, column 2. (page 99)

- Transfer important comments for each of the assets rated in the Asset Rating - Worksheet H to page 3 of Worksheet I, column 3. (page 99)

Needs Assessment Overview Report

Needs Assessment Overview Report - Worksheet I

Agency Name:

Community Area(s) Assessed:

Date CX Assessment Completed:

Social Disparities Capacity Assessment Overview - Worksheet I

Item	Rating	**Social Disparities Narrative Summary**: Overall, describe the program's strengths and weaknesses in relation to the 5 items assessed.
1. Tobacco-related Data Profile		
2. Tobacco Disparity Stategic Plan		
3. Social Determinants of Health Considerations		
4. Media Engagement		
5. Evaluation Inclusion		
RATING SUM		
Social Disparities Score (Rating Sum ÷25 x 100)	**(%)**	

Indicator Assessment Overview - Worksheet I

1 Indicator (# and Brief Title)	2 Community Readiness Score %	3 Stage of Change Score %	4 Policy Quality Score %	5 Policy Reach Score %	6 Total Policy/ System Status Score %	7 Total Indicator Score %	8 Indicator Narrative Summary: Items 1-5 (Worksheet G)

Asset Assessment Overview - Worksheet I

1 Asset (# and Brief Title)	2 Rating	3 Comments

Priority Setting Following a CX Needs Assessment

Moving Towards Workplan Objectives

A priority setting process will help to determine which of the previously assessed indicators and/or assets should be turned into objectives for the workplan. The objectives determine what types of program, media, and evaluation activities are to be undertaken and also communicate how the community will be different as a result of your project's efforts. By stating in your objectives the amount of change, or the minimum level of achievement expected as a result of your project's efforts, you can show others where you are now and how you will recognize that a benefit or change has occurred.

The number of objectives that go into scope of work depends on CDPH/CTCPs procurement requirements, the complexity of the issues, the community's readiness, the human resources available to complete the activities (both by staff and coalition/advisory committee members), and the budget available to finance various program, media, and evaluation activities.

Prioritizing the indicators and assets involves narrowing the list down to those things that are most important to accomplish during your contract period. CDPH/CTCP recommends that community members help project staff to identify the priorities and the primary focus of the objectives (voluntary policy, legislated policy, etc.) while staff and the local program evaluator should take responsibility for writing the objectives.

There are many models available to assist with priority setting and each agency can determine the most appropriate method to use. The following section is an overview of priority setting and serves as an introduction to the process.

Priority Setting: An Overview

There is no fast and easy method of selecting which indicators and assets you should include in your workplan. Priority setting within a community context is a complex process that involves consideration of a variety of factors, from funding limitations to the political climate. Keep in mind that the CX Needs Assessment scores are a starting point for the discussion on priority setting, and should not form the sole basis of your workplan decisions. Creating a balanced workplan in terms of comprehensiveness, effort, community participation and engagement, and meaningful community norm change around

The most common question facing an agency and/or community after completing a CX Needs Assessment is: "Now that I have assessed the indicators and assets, how do I determine which of them to include in the workplan?" It is helpful to decide upon a priority setting process, in which stakeholders and community members provide input on which indicators and assets should be included in the workplan, in order to most efficiently and effectively address the tobacco control needs of the community with the resources available.

tobacco control is the overall goal. In general, the lower overall score an indicator or rating an asset receives, the greater the need to work on that indicator or asset. Indicators are scored using a scale of 1 to 100. A score of 85% or above would be considered high, a score of between 70% and 85% would be fair, and a score below 70% would be low. Thus, a score of 69% or lower would indicate a high need to work on a particular indicator. Assets are rated on a 0 to 5 Likert scale, with a score of 0 indicating a low score and 5 indicating a high score. Thus, similar to indicators, the lower the score, the greater the need to work on a particular asset.

However, many factors besides the overall score or rating must also be considered when selecting issues to address in your workplan. For example, the following are questions you should consider when choosing indicators and assets to create objectives around:

- Will addressing the issue result in long-term, sustainable community change?
- Is there political will among decision-makers to address the issue? Can political will be obtained?
- Do community members feel enthusiastic about the issue? Is there community momentum around the issue?
- Do agency staff, coalition members, and/or community members have the resources needed to work on the issue? If not, can the resources be acquired?
- Will this issue address any emerging needs and challenges facing the community?

This is not an exhaustive list, but rather, examples of factors to consider when selecting indicators and assets for the workplan. The degree of importance assigned to each of these and other questions is completely dependent on the unique needs of each agency and/or community. Sample Priority Setting Model 1 shows how these questions can be incorporated into a formal priority setting process. (See: *Options for Prioritization Criteria* on page 106).

Many different voices and perspectives will be at the decision-making table, and these voices will likely have differing opinions. Involving key stakeholders in the priority setting process ensures community buy-in, which is important to achieving success and may also give you political justification if a controversial area is selected as a focus of your workplan. Regardless of the outcome, systematically identifying and selecting priorities is an important step towards creating your workplan, and it increases the likelihood of a successful project.

Priority Setting: 4 Questions to Guide the Process

Now that you have rated the indicators and assets, you'll want to consider four basic questions to help guide your priority setting process:

A. What model will be used for priority setting?
   The next section provides two basic models as examples: User-Selected Criteria and Score Chart Comparison.

B. What criteria will be used to compare indicators and assets?
   You'll want to select criteria and/or questions that will help you compare each indicator and asset. The criteria help identify what activities should be developed to best support a possible objective, how much effort would be needed to effectively support a particular objective, and how to balance resources among the objectives

created in the workplan. For examples, see *Options for Prioritization Criteria* listed under Sample Priority Setting Model 1.

C. What process will be used to vote, score, and/ or rank the indicators and assets?
It's important to define the process of how indicators and assets will be voted upon by the group. For example, either dot voting or the 100 votes method could be used as a voting tool. These examples are defined in Sample Priority Setting Model 1, Step 5.

D. How will final decisions be made?
You'll need to decide how much input the coalition/advisory committee members will have in terms of the final decisions. Will community participants be simply sharing opinions and recommendations, or will their votes count toward a final decision? Will participants choose the final objectives for the workplan, or will they simply narrow down the list for the agency to then decide? It is likely that you have already set expectations for participation at the beginning of your CX Needs Assessment meeting, however, the start of the priority setting process is a good time to remind participants of their roles.

After answering each of these four questions, it is important to communicate the process to all participants so they know what their role is and what is expected of them.

Sample Priority Setting Models

Priority Setting Model 1: User-Selected Criteria

The following model allows an agency and its community members to develop a list of criteria that are most important in determining priorities, and thus is entitled "User-Selected Criteria." This model has been successfully used by many CTCP-funded projects to set priorities and to develop objectives for their workplans. This model uses a five-step approach for priority setting and identifying the focus of objectives. As you read through the steps below, refer to page 107 for an example of a completed *Indicator and Asset Priority Setting Chart*.

Step 1: **Create a Chart**. Before the priority setting session with the community group, create an *Indicator and Asset Priority Setting Chart* with 5 columns titled **Indicator/ Asset**, **Overall Score**, **Key Findings/Special Needs**, **Prioritization Criteria/Rating**, **and Outcome Goal**. (Several flip chart sheets can be used for this purpose.) Transfer information from the completed indicator and asset rating worksheets to columns 1, 2, and 3 (columns 4 and 5 will be completed during the priority setting session).

Under **Indicator/Asset** (column 1) list each indicator and asset assessed. Under **Overall Score** (column 2) transfer the overall score given to the indicator or asset. Under **Key Findings/Special Needs** (column 3) state a few key findings that justify or support the overall score given and any population groups or geographical areas of the community that have special needs. Leave blank **Prioritization Criteria/ Rating** (column 4) and **Outcome Goal** (column 5) since these columns will be filled out during the priority setting session with everyone present.

Indicator and Asset Priority Setting Chart

Indicator/ Asset	Overall Score/ Rating	Key Findings/ Special Needs	Prioritization Criteria/Rating	Outcome Goal

Step 2: **Choose Prioritization Criteria**. At the priority setting session with your community group, identify three to five Prioritization Criteria to be used to prioritize the indicators and assets. See *Options for Prioritization Criteria* on page 106 for ideas for criteria or develop your own. This is a consensus process, and though not everyone may agree with the selected criteria, there should be general acceptance. The group may brainstorm new criteria, collapse, combine and/or delete criteria in order to come up with those that are the most important to the group. Write the agreed upon Prioritization Criteria in column 4 on the *Indicator and Asset Priority Setting Chart*.

Step 3: **Rate the Prioritization Criteria** under column 4. Divide the community group into subgroups of focus areas (e.g., Secondhand Smoke, Tobacco Promoting Influences, Availability of Tobacco, Cessation). Assign the indicators and assets to the subgroups that relate to the focus area. Using the selected Prioritization Criteria from Step 2, the subgroups should assign a value to their Prioritization Criteria for each indicator and asset using a scale of 0 to 5 (0 being not responsive and 5 being highly responsive to the criteria). Have each subgroup record their results on the *Indicator and Asset Priority Setting Chart* when the rating is complete.

Step 4: **Decide on Outcome Goal and Primary Focus** under column 5. Once the group sees the Prioritization Criteria and Ratings, they should discuss the Outcome Goal to be addressed if the indicator or asset is selected and turned into an objective. Indicators will typically have an outcome that falls into one of the following: voluntary policy/system change, legislated policy, or resolutions. Assets may have outcomes that address attitudes, beliefs, or process measures such as training or the amount of participation in local advocacy activities. List one Outcome Goal for each indicator and asset in your chart.

Step 5: **Vote!** Now that the *Indicator and Asset Priority Setting Chart* is complete, select a process for voting to help determine which assets and indicators to include in the workplan. One method that can be used is called dot voting. Once the chart is completed, each community member is given dot stickers and asked to vote for his/her top priorities based on his/her individual impressions of the information on the chart. Each member physically places dots next to his/her choices. To determine the number of dots per group member, use the "1/4 rule"—if 20 indicators and assets were rated and are being considered, give each member ¼ of 20, in other words, 5, dots. State the rules for applying the stickers, such as stickers may not be torn in half, only one sticker per indicator or asset, and each person must place one dot in each subgroup.

Another potential method is called 100 votes. Each participant is given 100 votes and can allocate them in any way they wish. Items that they feel deserve a high priority could be given 25 votes each. An item of medium priority but worthy of consideration may receive 10 votes. Some items may not receive any votes. Voting occurs by participants writing their number of votes next to each indicator or asset on the large chart blown up on the wall. The total number of votes is then added for each indicator and asset.

Options for Prioritization Criteria

1. **Coalition Enthusiasm:** The issue would be fun, enjoyable, and exciting to address. There is community momentum around the issue.

2. **Cost Benefit:** Working on the issue will result in an outcome that is greater than the human and financial resources needed to achieve the change (i.e., an assessment of how much bang for the buck you will receive).

3. **Effective:** There is research or evaluation data that indicate addressing the issue is effective at achieving the desired outcome.

4. **High Need:** The overall CX rating indicates a low score or there is an under-served population or geographic area that has a high need related to the indicator or asset.

5. **Long-Term:** Addressing the issue will result in a change that is sustained and becomes a part of the fabric of the community.

6. **Meaningful:** Addressing the issue will make a real difference in terms of the problem addressed.

7. **Political Will:** There is political will among decision-makers to address the issue.

8. **Practical:** The agency/community has the expertise, time, and resources to address the issue.

9. **Public Support:** Support by the public and/or community leaders for the issue is fair to excellent.

10. **Reach:** A large segment of the community will be reached or impacted.

11. **Stretch:** The issue reflects new ground for the group and may involve tapping into new skills that involve building the capacity of the group.

12. **Winnable:** It is likely that the group will succeed in achieving the action.

Indicator and Asset Priority Setting Chart
SAMPLE

	Indicator/Asset	Overall Score/ Rating	Key Findings/Special Needs	Prioritization Criteria/Rating	Outcome Goal
3.1	The extent our tobacco control program has built and engages a diverse coalition or advisory committee in designing and implementing tobacco control activities. Diversity is inclusive of ethnicity, culture, geography, and non-traditional partners (e.g., housing, employee development, law enforcement, parks and recreation, environmental groups).	2	Several ethnic groups are underrepresented in relation to their proportion in the community.	Coalition Enthusiasm: 5 High Need: 4 Public Support: 4 Winnable: 2 Overall: 4	Organizational Policy (Voluntary)
2.2.13	The number of jurisdictions covered by a public policy that prohibits smoking in the individual units of multi-unit housing including balconies and patios.	50%	Policies have been adopted and implemented, but only 30% of the population is protected by the policies.	Coalition Enthusiasm: 2 High Need: 4 Public Support: 0 Winnable: 2 Overall: 2	Legislated Policy
4.1.1	The extent to which evidence-based and culturally and linguistically appropriate behavior modification-based tobacco cessation services are available in the community.	75%	Cessation services are available, but not in Spanish.	Coalition Enthusiasm: 3 High Need: 2 Public Support: 3 Winnable: 5 Overall: 3	Systems Change

Priority Setting Model 2: Score Chart Comparison

This model addresses a method of comparing indicators and is not applicable to assets. It is called the Score Chart Comparison because two or more indicators are directly compared to each other using the completed rating tools and final scores as a basis for comparison. By examining the rating tools in depth, you can compare the many elements that go into the overall score and decide what is most feasible to work on.

Step 1: Create Score Charts

Using the completed indicator worksheets, you can make score charts similar to the ones shown below and post them on the wall for all to see.

Sample Score Charts

Indicator 1 - (3.2.1) Tobacco Retail Licensing (TRL)		
Community Readiness		76%
Scope of the Problem - Very Good		
Community Awareness - Excellent		
Community Support - Good		
Decision Maker Support - Good		
Earned Media - Very Good		
Policy Status		
Stage	60%	
Quality	40% - Fair	
Reach	60% - Good	
Total Policy Status Score		53%
Total Indicator Score		**68%**

Indicator 2 - (2.2.13) Multi-Unit Housing (MUH)		
Community Readiness		60%
Scope of the Problem - Excellent		
Community Awareness - Very Good		
Community Support - Good		
Decision Maker Support - Poor		
Earned Media - Fair		
Policy Status		
Stage	80%	
Quality	80% - Very Good	
Reach	80% - Very Good	
Total Policy Status Score		80%
Total Indicator Score		**68%**

Step 2: Discuss the Findings

Discuss the scores with the group to gain a sense of the overall level of need to work on each indicator. Looking at the Sample Score Charts above, you can see that each of these indicators received an overall score of 68%. As mentioned previously, an overall indicator score of 69% or below would indicate a high need to work on a particular indicator.

In the Sample Score Charts, Indicator #1, tobacco retail licensing (TRL), scored a 76% on the Community Readiness scale. The Scope of the Problem is Very Good: local data indicated that the lack of tobacco retail licenses in the community was a public health problem. Community Awareness is rated as Excellent. Community Support and Decision Maker Support and are both rated as Good. Earned Media coverage is rated as Very Good. The total Policy Status score for this indicator is 53%. The Stage of the policies is rated as 3 or 60%. Of the tobacco retail license policies assessed in the county, none have been implemented. The Quality of the policies is, on average, Fair, and the Reach of the policies is rated as Good. The overall score for this indicator is 68%.

Indicator #2, multi-unit housing (MUH), scored a 60% on the Community Readiness scale. The Scope of the Problem is rated as Excellent, Community Awareness is rated as Very Good, Community Support for the issue is rated as Good, Decision Maker Support is rated as Poor and Earned Media coverage is rated as Fair. The total Policy Status score for Indicator #2 is 80%. The Stage of the policies is rated as 4 or 80%. Of the multi-unit housing policies assessed in the county, only 1 is a legislated policy and it has been adopted and implemented. The rest of the policies in the community are voluntary. The Quality of the legislated policy is rated as Very Good – it meets the entire established standard provided by CTCP, and the Reach is also Very Good – it protects 75% of the population. The overall score for this indicator is 68%.

Post a blank Score Chart Comparison Table like the one below on the wall to facilitate comparisons. At the end of this step, record the indicator name and summarize the Step 2 findings on the chart below.

Score Chart Comparison Table

Indicator	Step 2 Findings	Step 3 Findings	Step 4 Final Decision

Step 3: Examine the Findings

In this step, the group uses "insider knowledge," past experience, and quantitative or qualitative data to take a closer look at Community Readiness and Policy Status scores.

Even though Indicator #2 scored fairly high on the Total Policy Status score (80%), the Decision Maker support was rated as poor and thus, Community Readiness was rated at only 60%. This outcome is possible, because the CX Needs Assessment addresses an entire community,

rather than just one jurisdiction in the county. It is possible that you may have several jurisdictions in which the political will for an issue may be low, while also having a very strong policy passed on that issue in another jurisdiction.

In comparing the two indicators, the TRL policy may be more feasible and practical to work on, given that Community Readiness scored higher for that indicator. Conversely, you may feel that although Community Readiness scored lower for MUH, that this is an area you can and want to address in your workplan. Perhaps you have knowledge and confidence that although political will may not be present right now, it can be obtained for this issue. Now you are ready to record the Step 3 findings on the Score Chart Comparison Table.

Step 4: Record the Final Decision

Using information from Steps 2 and 3, decide what type of intervention would be best and where the effort should be geographically focused. After the group makes the final decision, record it on the chart. Refer to page 12 for a completed Score Chart Comparison Table.

The Score Chart Comparison Model can also be used when comparing more than two indicators, and/or when comparing indicators that do not have similar scores.

Completed Score Chart Comparison Table

Indicator	Step 2 Findings	Step 3 Findings	Step 4 Final Decision
MUH	Only one policy passed in the entire county	Very strong political will for MUH policy in City X	Go for adoption and implementation in City X.
TRL	No implemented policies in the county.	Need to focus on policy implementation, especially in City Y.	Go for countywide adoption and implementation, or do implementation only in City Y.
Systems change	No adopted policies in the county.	3 major hospitals in the county, but 2 are governed by entities outside the county.	Go for adoption and implementation in 1 hospital.

Making Final Decisions for the Workplan

Once the priority setting process has been completed, you are ready to consider what goes into the workplan. In prioritizing for the workplan, you should consider not just the overall score, but the Community Readiness and Policy/System Status scores, as well as the jurisdiction(s) in which it makes the most sense to focus the effort. As discussed in the first section, the number of objectives that go into scope of work depends on CDPH/CTCPs procurement requirements, the complexity of the issues, the community's readiness, the human resources available to complete the activities (both by staff and coalition/advisory committee members), and the budget you have to finance various program, media, and evaluation activities. Your priority setting has helped you to determine some of these factors for the indicators and assets you assessed in your CX Needs Assessment.

An important consideration to factor into final decision making, is the creation of a balanced and comprehensive workplan. A balanced workplan meets the needs of the community, involves coalition members and community partners, is comprehensive, staggers efforts over the entire plan period, has objectives of varying intensity of effort, and addresses CTCP priorities as defined in the funding opportunity.

Creating a balanced workplan may mean that some indicators and/or assets that were identified as high priorities may need to be put off for future efforts. Working on the implementation of a previously passed policy effort to ensure that it becomes a community norm (e.g., a multi-unit housing indicator that scored in the mid-range) might be paired with a more intensive effort designed to raise community awareness and involvement in a new arena (e.g., the retail environment indicator that scored as a high priority). It is also advantageous to consider how the new workplan builds upon existing workplan efforts.

There are several ways decision-making around objectives can be done. Community members can narrow the indicators and assets down to a specified number. Project staff can then create objectives around those indicators and assets and bring them back to the community for a further cut and final vote. This can be done in person or via e-mail. Another option is for the community members to narrow down the indicators and assets to the exact number of objectives to be in the workplan by coming to a consensus during the priority setting meeting. Project staff can later create the objectives and share them with the community.

Whatever decision making process is used, it is important to communicate the final workplan objectives to all of those that participated in the CX Needs Assessment process so that everyone knows the final outcome. It's also a great opportunity to invite participants in the process to become engaged in workplan activities and help move the objectives forward!

Using the CX Needs Assessment Findings to Create Your Plan

1. **Priority Setting**: Use information from the Social Disparities Capacity, Community Readiness, and Policy/System Status assessments to set priorities and develop objectives for the workplan. Typically, the top 3-8 priorities will be developed into objectives. The number of objectives to be developed will depend on funding guidelines, resources, and the complexity or difficulty of the objectives. For in-depth guidance on priority setting, please see page 101 of this manual, Priority Setting Following a CX Needs Assessment.

2. **Social Disparities Capacity Assessment**: Use the findings from the Social Disparities Capacity assessment to inform how you do your work and to identify strengths that you can leverage and weaknesses that can be strengthened through activities written into your scope of work. For example: if your program has a tobacco disparity strategic plan, but it does not address any of the four strategies listed in the Social Disparities Capacity Rubric, you will want to revise your disparity plan to incorporate those strategies.

3. **Community Readiness Assessment**: Use the findings from the Community Readiness assessment to identify activities to include in the scope of work. For example:
    a. If there is a lack of quantitative evidence, then data collection activities should be planned.
    b. If awareness is low, then media and educational outreach activities should be developed to raise awareness about the issue, that a problem exists in the community, and that the community can do something to address the problem.

4. **Stage of Change Assessment**: Use the findings from the Stage of Change assessment to inform whether you should work on voluntary or legislated policy/system change approaches and to identify activities to include in the scope of work. For example:
    a. If the community is in the Planning/Advocating stage, then activities should include concrete action steps such as recruiting supporters, media activities, and developing model policy language in order to move into the next stage.
    b. If the community is in the Policy Implemented stage, then activities need to focus on institutionalization of business practices and enforcement to ensure compliance.

5. **Policy Quality and Reach Assessments**: Use the findings from the Policy Quality and Reach assessments to guide the development of objectives and whether objectives should focus on strengthening the quality of existing policies and/or extending the proportion of the population protected by legislated policies. For example: if on average, the legislated policies in the community area assessed meet only 50% of the established standard, you will want to strengthen the quality of those policies.

Communities of Excellence Overview for Coalitions

What is Communities of Excellence (CX)?

- CX is a community planning framework that is used to: systematically assess the tobacco control-related needs and capacity of a community, set priorities, and develop a plan of action.
- The goal of CX is to provide a "snapshot" of where the community is at in terms of tobacco control by gathering and analyzing qualitative and quantitative information.
- The CX process involves local community members and organizations in grassroots-level participation.

Why do we conduct a CX Needs Assessment?

- The CX needs assessment provides a systematic framework to assess a community's needs and assets and to engage community partners in program planning.
- The CX needs assessment lays the groundwork for agencies to develop meaningful tobacco control plans that emphasize community norm change strategies and gain community buy-in. This needs assessment framework is required to be used by local health jurisdictions receiving funding from the California Tobacco Control Program.
- CX strengthens local program evaluation efforts by creating a framework to compare changes in the needs assessment findings over time and allowing the state to compare similar interventions implemented in different communities. This allows the state to identify the factors that contribute to excellence and achievement in tobacco control.

What is being analyzed during the CX Needs Assessment?

- CX uses a specific list of measures for assessing needs and strengths in a community. These measures are called "indicators" and "assets."
    - Indicators focus on tobacco-related environmental or community level dimensions of population-based health. They look at what is happening locally at the community level around tobacco control issues and needs. The Indicator assessment is based on two measures: "Community Readiness" and "Policy/System Change Status."
    - Assets look at positive community factors or resources that help promote, support, and sustain local tobacco control efforts.
- In addition to analyzing indicators and assets, each county will conduct a Social Disparities Capacity assessment. This assessment looks at how tobacco use impacts priority populations in a community.
- The California Tobacco Control Program will provide instructions, worksheets, and data to help with completion of the needs assessment.

What happens after the CX Needs Assessment?

- The assessed indicators and assets will be compared with each other and narrowed down to a list of 3 to 8 priorities.
- These priorities will be developed into specific objectives for a tobacco workplan along with related activities, budget information, and evaluation plans.
- The number of objectives to be developed will depend on funding guidelines, resources, and the complexity or difficulty of the objectives.

Sample PowerPoint Presentation

COMMUNITIES OF EXCELLENCE IN TOBACCO CONTROL

Needs Assessment Training 2013

(Brief Version)

What is CX?

A community planning framework used to:

- Systematically assess the tobacco control-related needs and capacity of a community.
- Set priorities.
- Develop a plan of action.

Notes:

Idea came about from the tobacco control field in 2000.

CTCP realized that LLAs would benefit from a more systematic approach to assessing the tobacco control needs and capacities in their communities when developing their tobacco control programs. Lots of good work being done at county level. For example:

> One county was systematically marketing the same youth related policy initiative city by city.
>
> A health department was involving various grassroots community groups in data collection and policy development.

CTCP used these good ideas and progressive work to develop a statewide campaign.

What are the Goals of a CX Needs Assessment?

- Broaden the membership and participation of the community in local planning.
- Implement a framework for assessing community strengths and weaknesses.
- Develop meaningful workplans that emphasize community norm change strategies.
- Strengthen the evaluation of local program efforts.

Notes:

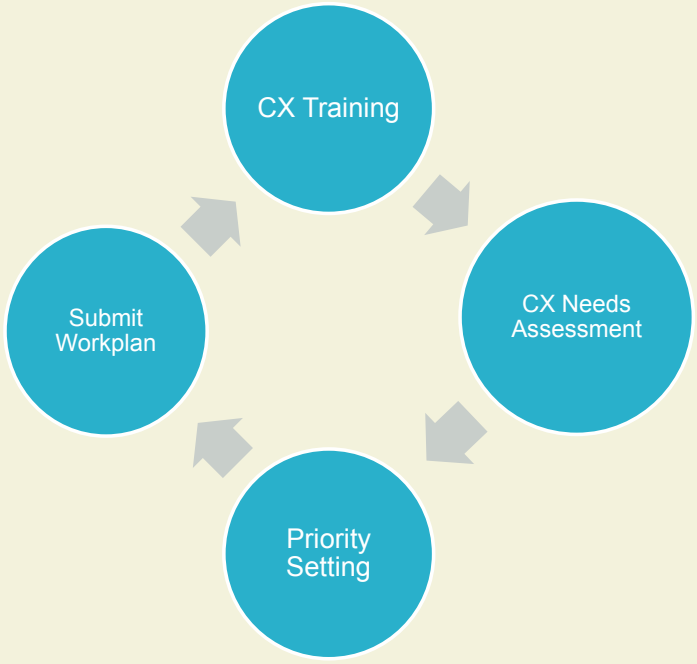
Broaden the membership - The process engages each community and their coalition to discuss available state and local quantitative and qualitative data and then rate how well the community is doing in relation to specific factors related to tobacco control. Involves local community members and groups in grassroots-level participation.

Implement a framework - An analysis of the community's strengths and weaknesses with respect to tobacco control.

Develop meaningful plans - Begins with community assessment; then determine high priority needs; develop a workplan that includes specific objectives, activities and evaluation. LLAs are required to do CX every 3 years in order to develop their workplan including related activities, budget information, and evaluation plans.

Strengthen the evaluation - Provides a community "snapshot" that can be looked at, compared to other communities, and analyzed later. Strengthen the evaluation of local program efforts by examining similar interventions over time and analyzing factors that contribute to success. CTCP uses CX data to track the progress of counties over time.

From CX to Workplan



Notes:

The CX process and workplan submission is a 3-year cycle. It begins with a training conducted by CTCP that is usually held in the Fall.

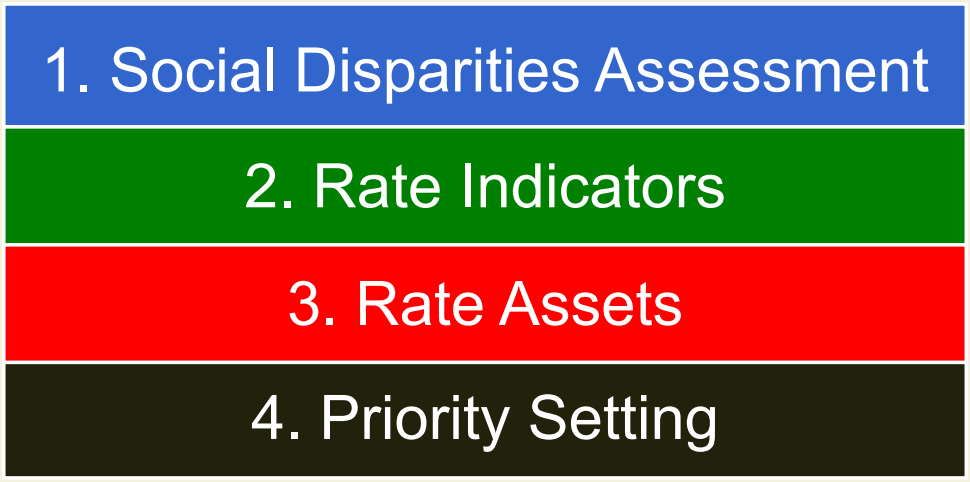
Following the training, you will conduct your CX needs assessment in your local health jurisdiction.

Next, you will conduct priority setting. Priority setting can be thought of as a bridge from CX to your workplan. Priority Setting occurs following the CX needs assessment. In this step, your coalition will look at the indicators and assets that were assessed, and prioritize them. As a result of the prioritization, some of the indicators and assets will stand out. The "stand out" indicators and assets will form the basis of the objectives for the workplan.

Each objective will contain related activities, budget information, and an evaluation plan. Findings from the Social Disparities Capacity Assessment will be used to strengthen your plan.

Finally, you will submit your workplan to CTCP in OTIS.

CX Steps



Notes:

CX consists of 4 steps in the process.

Step 1

1. Social Disparities Assessment

Social Disparities Capacity Assessment (Worksheet A)

This assessment is used to:

- Review how tobacco use impacts priority populations.
- Identify program strengths which can be leveraged.
- Identify weaknesses that can be improved through the addition of scope of work activities that reach out to and engage priority population groups in an effective and culturally relevant manner.

Notes:

The Social Disparities Capacity Assessment is meant to provide information that local health jurisdictions can use to strengthen their work with priority populations. For example: if your program has a tobacco disparity strategic plan, but it does not address any of the four strategies listed in the Social Disparities Capacity Rubric, you will want to revise your disparity plan to incorporate those strategies.

Social Disparities Capacity Assessment (A)

- The Social Disparities Capacity Measure is composed of 5 items:
    1) Tobacco-related Data Profile
    2) Tobacco Disparity Strategic Plan
    3) Social Determinants of Health Considerations
    4) Media Engagement
    5) Evaluation Inclusion

- A rating rubric will be used to help guide the discussion.

Notes:

Each item is rated on a six point (0 to 5) Likert scale of *Strongly Disagree, Somewhat Disagree, Neither Agree* or *Disagree, Somewhat Agree, Agree,* and *Strongly Agree*.

Social Disparities Capacity Assessment (A)

- Based on your coalition's knowledge of Social Disparities within your community and a discussion of relevant quantitative and qualitative data reviewed.
- Qualitative data sources such as key informant interviews, focus group findings, and coalition discussions can be used.
- You will rate each item and write an overall brief narrative summary.

Step 2

2. Rate Indicators

Notes:

CX consists of 4 steps in the process.

Indicator Assessment

Consists of 2 parts:

1. Community Readiness

2. Policy/System Status
   - Stage of Change
   - Quality
   - Reach

Community Readiness (Worksheet B)

- This assessment describes the community's readiness to work on a policy or system change.

- 5 measures:
  - Scope of the Problem
  - Community Awareness
  - Community Support
  - Decision Maker Support
  - Earned Media

- A rating rubric will be used to help guide the discussion.

Notes:

The first step in assessing indicators is the Community Readiness assessment. It will be rated by the coalition.

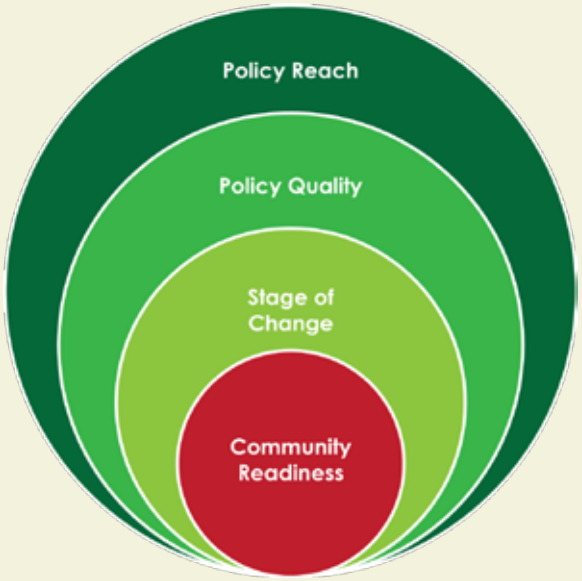
Explain each of the 5 measures:

- **Scope of the Problem**. To what extent do local, regional, state, or national data demonstrate the existence of a public health problem?
- **Community Awareness**. How much recognition is there among community members that a public health problem exists?
- **Community Support**. To what extent have community members demonstrated support for action?
- **Decision Maker Support**. To what extent have decision makers and community leaders demonstrated support for action (political will)?
- **Earned Media**. To what extent has there been unpaid neutral or positive media coverage in the past year relevant to this indicator?

Each measure is rated on a 0 to 5 Likert scale from none to excellent using a rating rubric. Prior to the CX needs assessment, you will prepare data packets to help assess each of these measures for each indicator being assessed. You will want to look at qualitative and quantitative data.

Policy/System Change Status

- This assessment describes the status of tobacco-related policy and systems within the community. It consists of 3 items:
  - Stage of Change
  - Quality
  - Reach



Policy/System Change Status

Stage of Change (Worksheet C)

- This assessment describes the stage of change that a community is at along a continuum of policy or system change.

- The six stages are:
  - No Formal Activities
  - Planning/Advocating
  - Policy/System Change Proposed
  - Policy/System Change Adopted
  - Policy Implemented
  - Compliance/Enforcement

Notes:

Stage of Change is the first item rated in the policy/system status assessment. It will be rated by the coalition.

Prior to the CX needs assessment, you will prepare data packets to help assess each indicator being assessed. You will want to look at qualitative and quantitative data.

Policy/System Change Stages		
Stages	Definition	Rating Scale
No Formal Activities	In this stage, general information gathering and fact finding are underway, but no formal activities specific to the indicator have been completed.	0
Planning/Advocating	In this stage, partnership development, strategy development (e.g., Midwest Academy Strategy Chart completed), specific data collection, and/or the provision of information and education to key opinion leaders are underway.	1
Policy/System Change Proposed	In this stage, a policy or system change has been drafted or proposed; a resolution may have been enacted; education and media activities are underway; and recruitment of partners beyond core supporters is underway.	2
Policy/System Change Adopted	In this stage: A. A voluntary policy or system change has been adopted and may be implemented OR B. A legislated policy has been adopted but not yet implemented. A legislated policy is one adopted by a government or a board authorized to set formal rules (e.g., county, city, tribe, housing authority, school board, transit board, fair board, hospital board, parks and recreation board, planning commission).	3
Policy Implemented	In this stage, a legislated policy(s) has been enacted and implementation is underway which may include: provision of training, communication to stakeholders notifying them of the policy and expectations, posting signage, collecting fees, and conducting compliance checks.	4
Compliance/Enforcement	In this stage, a high degree of compliance has been achieved with a legislated policy(s). Progressive action is taken to address non-compliance.	5

Policy/System Change Status
Stage of Change (Worksheet C)

Rating tips

- Mixed stage of change
- Resolutions
- Voluntary/administrative system changes

Notes:

Explain how to handle mixed policy situations.

Mixed stage - Give yourself the highest level of credit

Resolution - Highest rating is a 2

Voluntary - Highest rating is a 3

Policy/System Change Status
Quality (Worksheet D)

- This assessment describes the quality of **legislated policies** against a pre-defined public health quality standard. This standard was established for legislated policies adopted by a county board of supervisors or city council for the following types of policies:

- Tobacco Retail Licensing (TRL)
- Multi-Unit Housing (MUH)
- Outdoor Secondhand Smoke (SHS)
- Tobacco Sampling

Notes:

The Quality Rating will be calculated for the entire local health jurisdiction by CTCP for TRL, MUH, Outdoor SHS, and Tobacco Sampling ordinances.

The standard was created by the California Tobacco Control Program, California Department of Public Health (CTCP,CDPH) as a result of reviewing the literature, and working with ChangeLab Solutions, and local, state and national public health practitioners.

Policy/System Change Status
Quality (Worksheet D)

- The Quality Rating is a composite rating for the entire health jurisdiction. It is computed by calculating the quality rating for each ordinance adopted within the local health jurisdiction, summing the individual quality ratings for "like" types of ordinances and then dividing the sum by the total number of jurisdictions in the local health jurisdiction.

- A zero will be assigned for indicators that have no CTCP-assigned quality rating (e.g., legislated policies not rated by CTCP, voluntary policies, resolutions, and systems changes).

Notes:

Agencies will be able to modify the rating provided by CTCP, but must provide a narrative explanation if they do so. For example, if one or more policies have been enacted after CTCP provided the Policy Quality rating; an agency may raise the rating, but would need to provide an explanation in the narrative summary.

Policy/System Change Status
Quality (Worksheet D)

Policy Quality Rating Scale		
Items	Definition	Rating Scale
None	No policies relevant to the indicator have been adopted in the community area assessed.	0
Poor	On average, the legislated policies in the community area assessed meet 1% to 20% of the established standard.	1
Fair	On average, the legislated policies in the community area assessed meet 21% to 40% of the established standard.	2
Good	On average, the legislated policies in the community area assessed meet 41% to 60% of the established standard.	3
Very Good	On average, the legislated policies in the community area assessed meet 61% to 80% of the established standard.	4
Excellent	On average, the legislated policies in the community area assessed meet 81% to 100% of the established standard.	5

Notes:

The quality scale is composed of a six item continuum, rated on a scale of 0 to 5.

Refer to this table to explain the rating scale.

Policy/System Change Status
Reach (Worksheet E)

- This assessment describes the reach of **legislated policies** adopted by describing the proportion of the population within the local health jurisdiction that is protected by a specific policy change. Reach ratings are available for:

- Tobacco Retail Licensing (TRL)
- Multi-Unit Housing (MUH)
- Outdoor Secondhand Smoke (SHS)
- Tobacco Sampling

Policy/System Change Status
Reach (Worksheet E)

- Reach is calculated by summing the populations of the jurisdictions where a specific policy has been enacted and dividing that sum by the total population of the community area assessed.

- When no Policy Reach rating is available, the rating given will be zero.

Notes:

Agencies will be able to modify the rating provided by CTCP, but must provide a narrative explanation if they do so. For example, if one or more policies have been enacted after CTCP provided the Policy Reach rating; an agency may raise the rating, but would need to provide an explanation in the narrative summary.

Policy/System Change Status
Reach (Worksheet E)

Policy Reach Rating Scale		
Items	Definition	Rating Scale
None	No legislated policies have been adopted in the community area assessed.	0
Poor	1% to 20% of the population is protected by the policy change(s).	1
Fair	21% to 40% of the population is protected by the policy change(s).	2
Good	41% to 60% of the population is protected by the policy change(s).	3
Very Good	61% to 80% of the population is protected by the policy change(s).	4
Excellent	81% to 100% of the population is protected by the policy change(s).	5

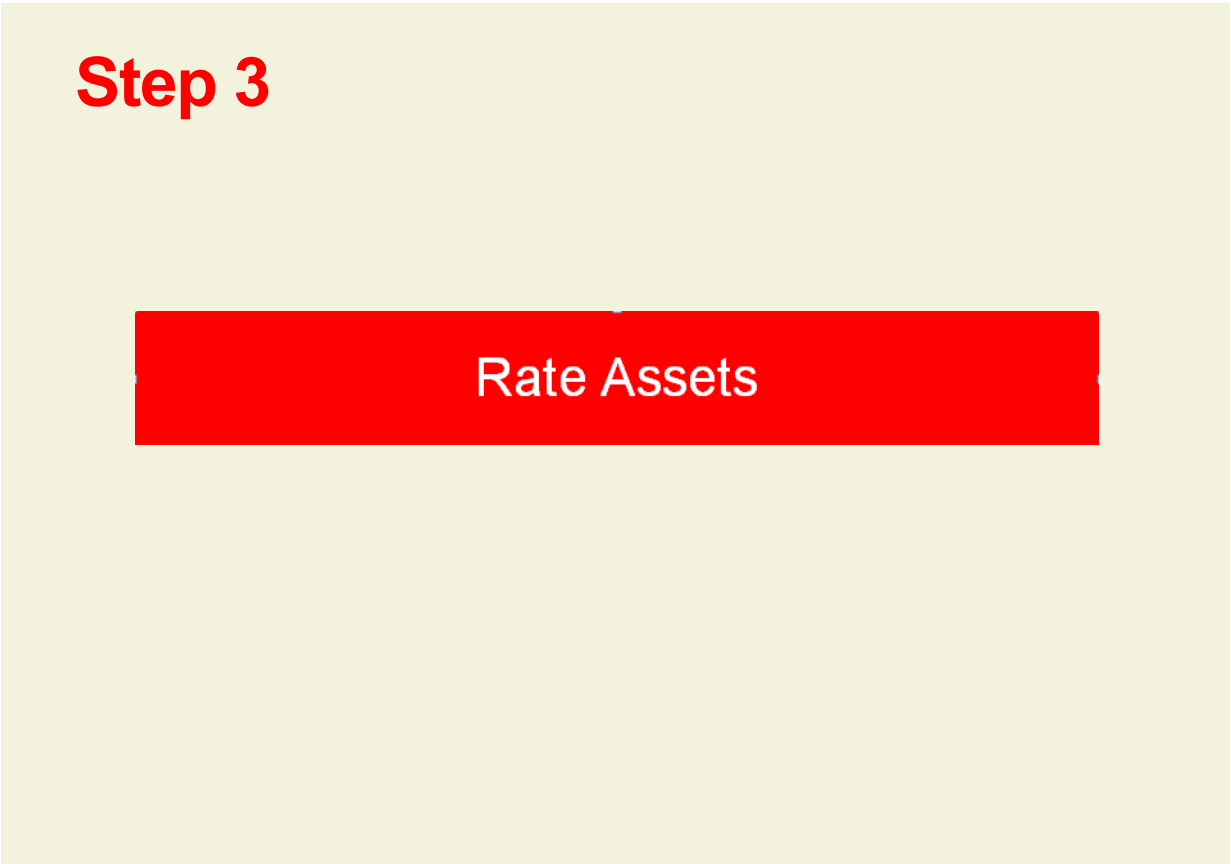
Notes:

The reach scale is composed of a six item continuum, rated on a scale of 0 to 5.

Total Indicator Score - Worksheet F

- Calculate the Total Policy System Status Score
- Calculate the Total Indicator Score

Indicator # 2.2.13	Indicator Title: MUH		
		#	%
Community Readiness	1 Transfer the rating sum and score from Worksheet B, Box B-1	14	56
Policy System Status	2a Stage of Change Transfer the rating and score from Worksheet C, Box C-1	4	80
	2b Policy Quality Transfer the rating and score from Worksheet D, Box D-1	3	60
	2c Policy Reach Transfer the rating and score from Worksheet E, Box E-1	2	40
	3 Total Policy/System Status Add lines 2a+2b+2c. Record that number. Divide the sum of (2a+2b+2c) by 15 to get the percentage.	(2a+2b+2c) 9	(2a+2b+2c) ÷ 15 60
Total Indicator Score	4 Total Indicator Score Add lines 1 and 3. Record that number. Divide the sum of lines (1 + 3) by 40 to get the percentage.	(1 + 3) 23	(1+3) ÷ 40 **58%**



Notes:

CX consists of 4 steps in the process.

Asset Categories

Community assets are organized into three major categories:

1. Tobacco Control Funding
   Availability of funding to support tobacco control efforts

2. Social Capital
   Extent to which people and organizations work collaboratively in an atmosphere of trust to accomplish goals of mutual interest

3. Cultural Diversity and Cultural Competency
   These assets address behaviors, attitudes, and policies that enable effective work in cross-cultural situations within the work environment and community

Rating Assets (Worksheet H)

- Rating is based on your coalition's knowledge of the assets and a discussion of all relevant quantitative and qualitative data collected and reviewed.
- A rating rubric will be used to help guide the discussion.
- In addition to rating the assets, you will write brief comments which explain and support the rating given to each asset.

Notes:

For Assets, the narrative summary is called "comments."

Rating Assets - Steps

- Review the rubric for the asset you are rating.
- Discuss relevant quantitative and qualitative data pertaining to asset.
- Reach a consensus on the rating for the asset. The rating scale ranges from 0 – 5.
- Record the rating and supporting comments.

Step 4

Priority Setting

Priority Setting

- No fast and easy method.
- The number of objectives depends on CTCP requirements, community readiness, human resources, budget, and complexity of the issues.
- What is most important to accomplish during the plan period?

Notes:

Priority setting is a complex process involving many factors from the political climate to funding limitations. Creating a balanced and meaningful workplan is the overall goal.

Questions to consider

- Will addressing the issue result in long-term, sustainable community change?
- Is there political will among decision-makers to address the issue? Can political will be obtained?
- Do community members feel enthusiastic about the issue? Is there community momentum around the issue?
- Do agency staff, coalition members, and/or community members have the resources needed to work on the issue? If not, can the resources be acquired?
- Will this issue address any emerging needs and challenges facing the community?

Notes:

These are just some questions that can be considered in choosing objectives for the workplan.

Communities of Excellence in Tobacco Control

CX Needs Assessment and Workplan Development Task Chart

Task	Responsible Party	Projected Completion Date
Preparation		
Attend CX Training.		
Create an overall timeline for the CX needs assessment and workplan development process.		
Review prior needs assessment processes, what worked well, and what needs improvement.		
Educate the coalition and/or advisory committee about the CX needs assessment and workplan development process.		
Identify indicators and assets to assess. (Refer to LLA Guidelines)		
Schedule CX needs assessment meeting(s).		
Assign responsibility for collecting data for each indicator and asset. Gather data on social disparities.		
Organize data collected into individual file folders for each indicator and asset, tracking the source and the time period that the data are from.		
Go into OTIS and complete the Policy Quality and Reach Worksheets (Worksheets D and E) for each indicator that applies. Include these in a file folder for the indicator.		
Solicit and summarize information about local tobacco control efforts in the community by searching the OTIS Local Project Directory and talking to other funded projects.		

Task	Responsible Party	Projected Completion Date
Preparation		
Identify groups and individuals beyond coalition members to participate in the CX needs assessment.		
Determine how you will organize groups for your CX needs assessment. Develop agenda, assign facilitators and note-takers, if applicable.		
Invite participants. Send participants data on indicators, assets, and social disparities to review prior to the CX needs assessment meeting, if applicable.		
CX Needs Assessment		
Hold meeting(s) with coalition and/or advisory committee members to rate indicators and assets and conduct the social disparities capacity assessment.		
Finalize the assessment worksheets and transfer the information to the Overview Report (Worksheet I).		
Prioritize indicators and assets. Narrow down those that will be developed into objectives and the focus/goal to be accomplished.		
Workplan Development		
Transfer information from the final worksheets into OTIS.		
Attend LLA Guidelines Training.		
Draft objectives. Work with local program evaluator to write measurable objectives.		
Share draft objectives with coalition and/or advisory committee and obtain ideas for major strategies to accomplish objectives.		
Assign staff to draft program activities, timelines, responsible parties, tracking measures, etc.		

Task	Responsible Party	Projected Completion Date
Workplan Development		
Complete draft workplan and budget in OTIS. Print copies and review for accuracy.		
Submit final workplan and budget to CDPH/CTCP in OTIS.		
Negotiate workplan and budget with CDPH/CTCP.		
Communicate final workplan and budget back to community members and elected officials.		
Recognize community members for their contributions.		
Summarize the process to serve as a guide for the next CX needs assessment.		